

NOMINATION OF ALEXANDER G. GARZA

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

OF THE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

NOMINATION OF ALEXANDER G. GARZA TO BE ASSISTANT SECRETARY
AND CHIEF MEDICAL OFFICER, U.S. DEPARTMENT OF HOMELAND SE-
CURITY

JULY 28, 2009

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NOMINATION OF ALEXANDER G. GARZA

TUESDAY, JULY 28, 2009

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Joseph I. Lieberman, Chairman of the Committee, presiding.

Present: Senators Lieberman, Akaka, McCaskill, and Collins.

OPENING STATEMENT OF CHAIRMAN LIEBERMAN

Chairman LIEBERMAN. Good morning and welcome to this hearing at which the Committee will consider the nomination of Dr. Alexander Garza to be Assistant Secretary and Chief Medical Officer of the Department of Homeland Security.

Senator McCaskill, if you have other matters to go to, I think not only out of respect for you as a fellow Senator, but as a fellow honored Member of this Committee, we would welcome you to do your introduction first and then we can give our opening statements.

OPENING STATEMENT OF SENATOR MCCASKILL

Senator MCCASKILL. That is very kind. Thank you, Mr. Chairman and Senator Collins, not only for the hearing this morning, but for your really special leadership of this Committee. You are both role models of how this should be done, and I would say that even if I were not on the Committee.

Chairman LIEBERMAN. Thank you.

Senator MCCASKILL. You work together closely, and you get past some of the food fights that go on around here over turf and who gets credit and all of that stuff, and it is remarkable. I am honored to serve on the Committee because of your leadership.

It is a special morning for me. People ask sometimes when you are having a rough week, because of the nature of our work and being in the public eye and being accountable for everything we say and do, why do you put up with it if you have to go through some of these things? Mornings like this morning are why you put up with it because you have the opportunity to meet and get to know people in your life who are the essence of public service and you have the opportunity to come into a room like this in the halls of the most deliberative body in the world and advocate for a man like Alex Garza.

I am proud to be here to introduce him this morning. I have to give a confession before I read my formal introduction, and that is

(1)

that his family is very close to me. His wife has worked for me for a number of years in a number of different jobs over my public life, and I remember when they met. I remember when they fell in love. I remember their wedding, mostly because I was a lot younger and a lot thinner—

Chairman LIEBERMAN. You do not have to go too far with this confession. [Laughter.]

Senator MCCASKILL. I remember the birth of all three children, who are here today. They are gorgeous boys. I remember the anxiousness and the anxiety that Melissa had when he was serving in Iraq. I remember all of it, and there is no man who is better equipped to step into these shoes today than Dr. Alex Garza.

I have known him for over 15 years and I am confident in saying there could not be a more qualified person for this position.

I first came to know Dr. Garza when he volunteered as a medical expert on the methamphetamine task force I directed as Jackson County Prosecuting Attorney. In recognition of his work, he was awarded the Presidential Citation by the Office of National Drug Control Policy.

But his story of service and dedication to the medical community did not start here. Dr. Garza grew up as one of five brothers in a Maryland Heights, Missouri, middle-class suburb of St. Louis. Being one of five children, he learned the valuable art of negotiation at an early age. But more importantly, his mother, who worked the night shift as a nurse in the local emergency department, taught him the value of hard work and serving his community, skills that will serve him well as Assistant Secretary, if confirmed.

While attending college, he decided he wanted not to just learn from the books, but to experience medicine from the ground up. He delayed attending medical school to work as a paramedic in Kansas City so he could learn from the front lines. He continued his work as a first respondent as a flight medic all through medical school, working weekends and holidays to put himself through school.

He graduated from the University of Missouri School of Medicine and began the next stage of his emergency medical training at Truman Medical Center in Kansas City, Missouri. On top of all this, he also heeded his mother's example to serve by joining the United States Army Reserves Medical Corps.

He ultimately chose to make his career in medicine about public service when he accepted a position as a member of the faculty at the Truman Medical Center. His tenure was interrupted when he was called into active duty in service of Operation Iraqi Freedom, leaving behind his wife, who was in law school at the time, and his then two small children.

Dr. Garza and his team were responsible for rebuilding health care in Iraq. What he found were medical schools with out-of-date textbooks and decades-old journals. True to his form, he orchestrated a textbook donation program that led to medical schools from across the United States sending texts to fill the library shelves of schools throughout Iraq. Because of Dr. Garza's tireless work rebuilding hospitals and clinics, he became a trusted member of the Iraqi medical community and developed important strategic relationships. In addition, he also cared for an occasional Iraqi

sheik, the soldiers in his unit, took turns at his post, and cleared buildings when needed.

When his tour was extended for an additional 6 months, I consoled Dr. Garza's wife, Melissa, a longtime member of my staff, who came to me in tears after learning her husband would be spending Christmas in a bombed-out shell of a building where he had volunteered to assist the forward surgical team during a full-scale offensive operation in Samarra. He finally made it home to his family and was awarded the Bronze Star as well as the Combat Action Badge.

His career in academics and public service immediately resumed when he returned to direct emergency medical services for the City of Kansas City and also returned to the faculty at Truman Medical Center. During this time, Dr. Garza recognized that outcomes for cardiac arrest patients could be improved, and he created a new cardiopulmonary resuscitation protocol that challenged conventional dogma. His ability to think outside the box led to a doubling of the survival time for cardiac arrest patients in Kansas City. For his work, he was awarded the Young Investigator Award by the American Heart Association. Because of his work, health care workers around the world are now changing the protocols and the way they resuscitate patients.

Dr. Garza is one of those rare individuals who, through hard work and sacrifice, has improved the lives of those around him. He has saved the lives of his patients, working in the emergency room, taught compassion and clinical skills to medical students and residents, furthered medical science by publishing numerous articles in peer-reviewed scientific journals, served his country at war, and improved the way pre-hospital care is rendered across the globe.

It is with great pleasure and it is an honor that I have the opportunity to introduce Dr. Alex Garza to the Committee. I have every confidence that under his leadership, the Office of Health Affairs will serve the Secretary and the President and the Department of Homeland Security in an effective and meaningful way.

Thank you, Mr. Chairman.

Chairman LIEBERMAN. Thank you, Senator McCaskill, for a very impressive and, I would say, obviously heartfelt, and for us moving, introduction. I would say that Dr. Garza deserves it all. I thank you for taking the time to come and deliver it.

I don't know when we have last had an introducing Senator kiss the nominee. [Laughter.]

It is a good way to go.

Senator McCASKILL. It is progress. [Laughter.]

Chairman LIEBERMAN. Thank you very much, Senator McCaskill.

There is not much I can add to that really extraordinary and very compelling introduction. I will just say a few words about the position for which you have been nominated.

The position of Chief Medical Officer at the Department of Homeland Security was created by the Post-Katrina Emergency Management Reform Act of 2006 that was authored, I am proud to say, by Senator Collins and me, following this Committee's 8-month investigation into why the response of our Government to Hurricane Katrina was so poor. The Post-Katrina Reform Act reconfigured the Federal Emergency Management Agency (FEMA)

so that it could, for the first time in history, respond really in an excellent way to natural disasters and also beyond that to catastrophic disasters equivalent to the swamping of New Orleans in 2005.

Among the new positions created to achieve that end, which was better protection of the American people in crisis, was the position of Chief Medical Officer to be the chief and principal advisor to the Secretary of Homeland Security and to the Director of FEMA on both medical and public health issues.

Among the responsibilities of the Chief Medical Officer is coordinating the Department's response not just to natural disasters, but to terrorism, including particularly bioterrorism, which is a special focus of this Committee in this session, ensuring coordination of all medical preparedness and response activities at the Department, and coordinating the Department's workforce health protection. In short, the Chief Medical Officer is responsible for ensuring that the Federal Government is ready, ready to carry out a quick, comprehensive, and effective medical response to disasters, both natural and unnatural.

I would say that it is especially important, and I know the Secretary feels this, that we fill this position right away.

As chief medical advisor, Dr. Garza, should you be confirmed, you will play a vital role in our Nation's response to the H1N1 outbreak, which is continuing. Though many Americans and a lot of the news media have turned to other matters, this epidemic has continued to spread. Cases now number over 1 million in this country, and the flu has not subsided, as expected, this summer. It has not surged up in numbers, but it has continued at pretty much the same pace, which is not what most public health experts predicted. It continues to be most problematic for children and young adults, and unfortunately, there is every indication that it will spread more rapidly in the fall when the traditional flu season returns. Obviously, it is imperative that we be ready for that and we get the public ready for that, and I want to ask you about that during the question and answer period.

The next section of my prepared statement was a recitation of your really quite extraordinary, patriotic biography,¹ but Senator McCaskill did such a great job, I will just express in closing here my admiration and gratitude for your experience and your service to your country and how much I look forward to hearing your opening statement and then questioning you as you go forward on this nomination. Thank you.

Senator Collins.

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

I join you in welcoming Dr. Garza to our Committee today. As is so often the case, the Chairman and I have written opening statements that are virtually identical. I, too, went through the history of the creation of the Chief Medical Officer in response to our investigation into the failed response to Hurricane Katrina. I, too, outlined the responsibilities and duties of the Chief Medical Officer.

¹The prepared statement of Chairman Lieberman appears in the Appendix on page 19.

I, too, talked about the threat of H1N1 and the fear that experts have that it is going to return in the fall and winter with even higher rates of infection and increased severity.

So rather than repeat what the Chairman has just said, let me just wrap up my comments by saying that I am particularly interested in hearing Dr. Garza's thoughts on our ability to surge medical resources to respond to major medical events, whether caused by a pandemic flu, the intentional release of a deadly biological agent, or the detonation of a dirty bomb.

Last year, our Committee held a series of hearings on our preparedness for the detonation of a nuclear device in a large urban area, and we found many troubling gaps in our medical surge capabilities. I contrasted that to what I saw in Israel, where there is such preparedness to surge medical resources. I think we have a long way to go.

In that area, Dr. Garza, having served as an emergency doctor in both military and civilian settings, can help us improve. I look forward to hearing his testimony today.

Thank you, Mr. Chairman, and I would ask that my full statement be inserted in the record.¹

Chairman LIEBERMAN. Without objection, so ordered. Thank you, Senator Collins.

That was actually a very good and different point that you made at the end. I was thinking as you were saying what you did that I remember saying when we switched roles and I became Chairman and you Ranking Member that nothing would change except our titles, and I realize that one thing has changed, which is that I get to give our speech first.

Senator COLLINS. That is so true. [Laughter.]

Chairman LIEBERMAN. Dr. Garza has filed responses to a biographical and financial questionnaire, answered pre-hearing questions submitted by the Committee, and had his financial statements reviewed by the Office of Government Ethics. Without objection, this information will be made part of the record, with the exception of the financial data, which are on file and available for public inspection in the Committee offices.

Dr. Garza, our Committee rules require that all witnesses at nomination hearings give their testimony under oath, so I would ask you to please stand and raise your right hand.

Do you swear that the testimony you are about to give to the Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Dr. GARZA. I do.

Chairman LIEBERMAN. Thank you. Please be seated and please proceed with your statement and feel free to introduce your family.

TESTIMONY OF ALEXANDER G. GARZA, M.D.,² TO BE ASSISTANT SECRETARY AND CHIEF MEDICAL OFFICER, U.S. DEPARTMENT OF HOMELAND SECURITY

Dr. GARZA. Thank you for those remarks. Good morning, Chairman Lieberman, Ranking Member Collins, and distinguished Mem-

¹ The prepared statement of Senator Collins appears in the Appendix on page 20.

² The prepared statement of Dr. Garza appears in the Appendix on page 23.

bers of the Committee. I am humbled and honored to be a nominee of President Obama and to seek your support today for my nomination to be Assistant Secretary for Health Affairs and Chief Medical Officer of the U.S. Department of Homeland Security (DHS).

If I may, Mr. Chairman, I would like to thank my wife, Melissa, and my three sons. This is Alex—

Chairman LIEBERMAN. Good morning, Alex.

Dr. GARZA [continuing]. Samuel, and young Danny.

Chairman LIEBERMAN. Good morning.

Dr. GARZA. They have supported me here today as well as throughout my career.

I am grateful for the leadership of this Committee for ensuring the Nation is prepared to respond to all hazards and all threats. The position for which I am nominated was authorized by the Post-Katrina Emergency Management Reform Act of 2006. Therefore, it is because of the work of this Committee investigating the government's response to Hurricane Katrina and the important legislation that all of you championed as a result that I stand before you today. I want to thank you again for your leadership.

I believe the role of the Chief Medical Officer is one of the most challenging and rewarding roles for a physician in the Federal workforce. The position not only requires experience and knowledge in medical preparedness and response, but also demands an understanding and awareness of intelligence and security issues. My background as a local and State public health official, coupled with my military service, makes me uniquely qualified for this position.

My career has been dedicated to public service. I appear before you today asking that you support my nomination so that I may continue serving our country.

If confirmed, my priorities will be as follows. To continue to build and strengthen the relationships between the Office of Health Affairs (OHA) and its partners in DHS. The foundation established by these relationships will permit OHA to deliver the best possible advice and guidance to the Secretary, the Administrator of FEMA, and our other component services.

Two, to continue building OHA's capacity. OHA must continue to expand on its ability to respond to the various threats and challenges of the DHS. The Office must adopt an all-hazards and all-threats approach in order to prepare for a constantly changing landscape of natural and manmade disasters and catastrophic events. The office must be able to quickly assess and adapt to the circumstances and to deliver rapid, yet sound, response.

Third, protecting the DHS workforce. Those protecting the homeland are absolutely vital to the mission of the Department. OHA must continue to offer appropriate guidance to the DHS's components in order to protect those who protect us.

If confirmed, I will pursue these three priorities. I would build and strengthen OHA's relationships with all its component services, expand its capacity to respond to all hazards and all threats, and I will work with OHA's efforts on protecting the health of the DHS workforce.

In closing, I am honored by the President's and Secretary Napolitano's faith in my ability to effectively lead this office and would like to put my knowledge and experience to use in continued

service of my country. I look forward to working with this Committee, if confirmed, and I am glad to answer any questions that you may have. Thank you.

Chairman LIEBERMAN. Thank you, Dr. Garza.

I am going to start my questions with the three standard ones that we ask of all nominees. First, is there anything you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated?

Dr. GARZA. No, sir.

Chairman LIEBERMAN. Second, do you know of anything, personal or otherwise, that would in any way prevent you from fully and honorably discharging the responsibilities of the office to which you have been nominated?

Dr. GARZA. No, sir.

Chairman LIEBERMAN. And third, do you agree without reservation to respond to any reasonable summons to appear and testify before any duly constituted Committee of Congress if you are confirmed?

Dr. GARZA. Yes, sir.

Chairman LIEBERMAN. Thank you.

We will start with a first round of questions of 7 minutes per Senator.

As I indicated in my opening statement, in a relatively young Department of Homeland Security, the Office of Health Affairs is itself a relatively young office. The position of Chief Medical Officer was not formally authorized until 2006. Since then, the office, OHA, has grown to over 100 in staff and a budget of approximately \$150 million, but in many respects, it is still young and still in its formative stages.

I want to ask you, because you are coming in to manage at this point—you will be more than just a singular advisor to the Secretary, you have got an office there—to just develop a little bit more of what your priorities and vision is for the future of OHA.

Dr. GARZA. I understand and I can fully appreciate the relative newness of the office and what challenges it brings with it.

The priorities that I envision for the office, if confirmed, are as outlined in my opening statement. When I met with the staff over the last couple of weeks to try to get a better handle on what the office was doing, I asked each program manager at the end of our session, what was their biggest challenge. Without any hesitation and overwhelmingly, the program managers said the biggest challenge was integration and cooperation with other agencies. So I believe that should be at the very top of my list, trying to build relationships with our Federal agencies, Department of Health and Human Services (HHS) in particular, but as well as our other agencies since the Department of Homeland Security spans a greater breadth and depth than just medical issues.

So we would do this, what I described as both vertically and horizontally. We would go across our components. The office would reach out to its other agencies and other partners. But the office should go up and down, as well, and by that I mean we should be able to cooperate and work with State, local, tribal, public health providers, first responders, law enforcement, emergency management, as well as critical infrastructure and key resources.

So that would be one of my priorities, and the second would be making sure that the workforce is protected. I know that there are challenges that have been identified by this Committee. I know it is the Secretary's priority to make sure that the workforce is getting clear guidance, that they are operating with the best equipment, with the best training, with the best knowledge so that they can execute their duties.

I have particular interest in this because of my military background as a battalion surgeon, where I fulfilled this role in making sure our soldiers were medically prepared to go to war, including vaccinations, and that included smallpox and anthrax, taking care of them while they were deployed, as well as doing post-deployment medical-related issues. So I fully understand, comprehend, and am passionate about that, as well.

One of my other priorities is to build capacity within the office. I realize that the office spans a great many things. However, we must continue to build on a foundation of excellence, and that sort of fits in with building our relationships, as well. We have to build that capacity in order to get better information, in order to work collaboratively in building that capacity so that when we are advising the Secretary, the FEMA Administrator, and whoever else our customers are, be it the other Federal agencies, this Committee, State or local governments, that we are able to give them the very best product, the very best advice that we can.

Chairman LIEBERMAN. Are there particular areas in which you want to build the capacity of the office, where you think it is short now?

Dr. GARZA. Yes, sir. One of the areas that is of particular interest to me is in the area of biosurveillance. I do have some experience in this in the civilian world. I have worked with various emergency medical service (EMS) providers. During my time as a Medical Director in Kansas City, we made it a point to develop syndromic surveillance using emergency data.

Chairman LIEBERMAN. And this biosurveillance is to set up a system where you would have as close to immediate notice as possible of a potential biological attack?

Dr. GARZA. Absolutely, sir. And so with the syndromic surveillance, what we were doing is we were looking for any patterns that were out of the normal for the community.

Chairman LIEBERMAN. Please say a little more about what syndromic is, as in syndrome.

Dr. GARZA. Yes. And so what we tried to develop for the City of Kansas City was looking at all of the calls that came into 911. Now, the dispatch center for the EMS service uses computer algorithms to arrive at what we call presumptive conditions. So by interrogating the caller on a series of questions, we arrive at what we think is the most likely diagnosis or complaint. Those are all coded on computer. It is all in real time.

One of the beauties of 911 data, which sets it apart from emergency department data, which I have written papers on, is all these calls are geocoded, and so we know exactly where the caller is calling from, so we know where the incidents will be coming from, as well.

So we collect this data, and we do a continuous sweep of the computer, and we plot it up against what we know our normals are for that time of day, for that time of year, things like this.

Chairman LIEBERMAN. That is a very good idea. I was thinking you were going to talk about detection devices around areas, in other words, technological devices——

Dr. GARZA. Sure.

Chairman LIEBERMAN [continuing]. But what you are really talking about is taking advantage of an existing flow of information and trying to draw from it quickly——

Dr. GARZA. Exactly.

Chairman LIEBERMAN [continuing]. A warning sign that something is happening.

Dr. GARZA. Exactly. And the way we reasoned it is that we can analyze this data much quicker than waiting for the emergency department to pull the data together from multiple different sources. One of the beauties of emergency dispatch data, as well, is that it is a single center. Everyone who calls 911 calls to the center. So you are not pulling data from different emergency departments to try to bring all that data together. You have a single source. You have a single algorithm. You have a single pattern that you can look at in order to decide if this is something that is out of the ordinary.

Chairman LIEBERMAN. So what are you thinking of, trying from the Chief Medical Officer's position to advocate that at least the major urban areas in the country do similar ongoing screening of 911 calls?

Dr. GARZA. Sure. Presently, there are quite a number of communities that do this. That was in reaction to what we had done.

Chairman LIEBERMAN. Right.

Dr. GARZA. So currently, this monitoring is done in over 80 cities around the country, including Canada. So it does seem to be a fairly robust and equitable system.

I think the point of me bringing that up, though, is to explain that we need to start thinking a little bit more globally on where we can look for syndromic surveillance and for other data bits in order to give us a complete picture of what is going on out in the community.

Chairman LIEBERMAN. My time is up. I want to say I hope that, if you are confirmed, and I sense that you understand this already, you will not simply be there waiting for the Secretary to ask you for advice or the FEMA Director, but that in the areas of readiness, public health, medical, you will be a very aggressive advocate and initiator of policy.

Dr. GARZA. Absolutely, sir.

Chairman LIEBERMAN. Thank you.

Dr. GARZA. Thank you.

Chairman LIEBERMAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Dr. Garza, I was very pleased to hear you say that workforce protection is a high priority for you. The Department is going to have to make a decision on whether or not Customs and Border Protection officials, for example, should receive priority for vaccination against the H1N1 virus once the vaccine is fully developed. In addi-

tion, the Department needs to develop more complete protocols for the FEMA Emergency Response Teams that are deployed to disaster areas so that they are protected from hazards that they face.

Your predecessor made it a priority that OHA would create a uniform set of policies for workforce protection. Yet in response to questions from the Committee, you seem to see your role more as advising the Chief Administrative Officer. I would tell you that is not what we envisioned. You are supposed to be the direct and principal advisor to the Secretary on a whole host of issues, including workforce protection.

I am going to ask you again what role you think that your office should play when it comes to DHS workforce protection.

Dr. GARZA. Yes, ma'am. I share in your concerns for workforce protection, and I know it is one of the top issues on the Secretary's list, as well. So let me try to assuage your fears of us abdicating our role.

OHA has a very strong presence with the Secretary. I view the role of the Chief Medical Officer and the Office of Health Affairs as being intimately involved in whatever posture that the border takes, that our workforce takes, and giving the Secretary the very best advice that we can, as well as assisting in developing policy.

I do have some experience in this, I think as is evidenced by my biography, while working with the military. I was the chief advisor to the battalion as the battalion surgeon and as well as to the division staff on civil military operations. And so I do have some familiarity with that.

Now, as the battalion surgeon, you assume a lot of roles, and so one of those is what sort of posture should your soldiers take while operating in a hostile environment, and that includes chemical protection, protection against known biological threats, and things like this. So I am completely comfortable with that role.

As far as developing policy and procedures for our workforce, let me emphasize that our workforce is the most important asset of our organization, and there are no doubts that I, as well as my staff and the Secretary, take that role very seriously.

Senator COLLINS. I just want to make very clear that we look to you to develop those protocols and provide that advice. It is not the job of the Chief Administrative Officer or the Under Secretary for Management. It is the job of your office, and I am confident from your response, in contrast to your response to the pre-hearing questions, that you do understand that.

I want to go on to two other issues in the time that I have. Last year, the Commission on the Prevention of Weapons of Mass Destruction (WMD) Proliferation and Terrorism found that a biological attack was "more likely than not" to occur somewhere in the world by the year 2013. Seven years ago, we authorized the Select Agent Program in the wake of the anthrax attacks on our Capitol and on the Postal Service. I believe that DHS needs to play a stronger role in evaluating the security of labs that are working with the most dangerous pathogens.

I, for one, was surprised and alarmed to realize how weak a regulatory structure we have and how dispersed these pathogens are in labs all over the country, many in academic or medical settings, with very low levels of security.

Do you believe that we need to reexamine and strengthen the regulation of labs that are housing these very dangerous pathogens?

Dr. GARZA. Yes, Senator. I, as well, share your concern about biological agents with a potential to do harm to the community. As far as the biosafety level (BSL) labs and issues like that are concerned, I know that the Office of Health Affairs will work collaboratively with the Office of Science and Technology, which is, I believe, mostly charged with biosecurity instruction and things like that.

So where I believe, as Chief Medical Officer—if confirmed—the Office of Health Affairs can be of assistance is, once again, getting all of the best science available to advise the Secretary on the threats that this would pose to the community as well as working with our component services and the Office of Science and Technology in developing plans to make sure that if there were such an event, we would have a robust response, as well as discussing any security issues and/or things of that nature. As a physician and as a community provider, I think it is important that we get the best available evidence for the Secretary to make those decisions.

Senator COLLINS. I hope that you will also work with the Members of this Committee.

Dr. GARZA. Absolutely, ma'am.

Senator COLLINS. I personally think that we need to strengthen the law in this area and come up with a risk-based security scheme where greater level of scrutiny and regulation would be applied to labs with the most dangerous pathogens and that we come up with that kind of approach, similar to the approach that we took with chemical facilities security.

Dr. GARZA. Yes, ma'am.

Senator COLLINS. I see my time has expired, so I will wait for the next round. Thank you.

Chairman LIEBERMAN. Thanks, Senator Collins.

I just wanted to echo what Senator Collins has said. This will be one of our legislative priorities this year, which is to legislatively beef up the oversight and protection that we provide to the American people from bioterrorist attack. I mean, you are now moving into a position, if you are confirmed, which we live with. We are all about defense. We are all about defense of the homeland in the post-September 11, 2001, period, and in some ways we spend a lot of time imagining worst case scenarios. But after September 11, 2001, that is what we have got to do. And this is one, particularly coming off of the Graham-Talent WMD Commission report, that I think we really want to focus on, and I will come back with one or two questions afterward.

Senator Akaka, good morning. Thanks for being here.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA. Thank you. Good morning.

Let me congratulate you, Dr. Garza, for being the nominee and welcome you and your beautiful and handsome family. It is good to see Melissa here and also—is that Alexander Junior?

Dr. GARZA. He has a different middle name, sir. I would not want to burden him with my name.

Senator AKAKA. I also welcome Samuel, Daniel, and the rest of your family here, and also friends and supporters, as well. Thank you for being here.

Dr. GARZA. Thank you.

Senator AKAKA. As you know, Dr. Garza, the Office of Health Affairs is tasked with protecting our country from bioterrorism as well as natural agents that threaten our health. Given the increasingly difficult challenge of protecting our Nation, I urge you to focus on working collaboratively and communicating effectively with partner agencies and other stakeholders. It was good to hear your priorities about strengthening relationships with other agencies. There are a lot of agencies and departments where the relationships have to be strengthened.

Like you, I believe that our workforce is our most valuable asset, and I understand that one of your priorities is to protect and help build the morale of that workforce. I hope in particular that you will focus on the growing shortage of the Federal veterinarian workforce and how it will affect our public health and food safety.

Dr. Garza, your wide-ranging experience in emergency medicine, academia, and the military gives me confidence that you will bring a valuable perspective to the office. Again, I congratulate you on your nomination and look forward to working with you and again commend you for your priorities.

As I mentioned in my opening remarks, I am concerned about the Federal veterinarian workforce and its shortages. I requested that the Government Accountability Office (GAO) conduct a comprehensive review of the Federal veterinarian workforce and held a hearing in February of this year, which focused on the challenges facing this workforce. GAO found that within the next 3 years, more than one-fourth of the veterinarians at key agencies for public health, homeland security, and food safety will be eligible to retire.

As you know, OHA veterinarian agro-defense personnel provide advice on zoonotic diseases and agricultural security related to food and water. Keeping in mind that most Federal veterinarians work outside DHS, what steps would you take to address this critical workforce challenge so that Federal veterinarians are able to help address the Nation's vulnerabilities in these areas?

Dr. GARZA. Senator, I share your concern about our veterinarians and their declining numbers in the workforce.

If I may, I would like to discuss how the Office of Health Affairs intersects with veterinarian medicine. Now, as with almost the whole of DHS, it is multi-ingrained with many different aspects and partners and things like that, and the same is true of the Office of Health Affairs. The Office of Health Affairs does not necessarily just deal with human disease. We value the all-hazards, 360-degree situational awareness, and that includes zoonotic disease as well as agricultural issues, as well.

If we take a look at the big picture, we would understand how important the surveillance, the response, and the handling of zoonotic disease is to the importance of human health. So I share in your concerns that we must keep a robust, a very active and involved participation with our veterinarian colleagues, who, by the way, are some of the smartest people that I have ever met.

So as a role of the Chief Medical Officer and the Office of Health Affairs, I believe it is important that we support our veterinarians and that we enhance their capabilities, as well as interacting with partners in other agencies, such as the FDA and the Department of Agriculture, in order to leverage our abilities with them and also to showcase the importance and the value that they bring to the table, as well as push this down to the State and local agricultural partners and our veterinary partners.

So I value their input. They are an important part of the Office of Health Affairs, and if confirmed, I would further continue to try to improve our relationship with them and improve their standing in the Federal workforce.

Senator AKAKA. Dr. Garza, until recently, the Department of Health and Human Services operated immigrant health services while working with Immigration and Customs Enforcement (ICE) under a Memorandum of Understanding. Now, the Division of Immigration Health Services operates within ICE. In recent years, ICE's medical services have come under great scrutiny due to the numerous reported deaths.

What role do you expect OHA will play in guiding the decisions and policies to improve the oversight and quality of medical care for immigrant detainees?

Dr. GARZA. Yes, Senator. Again, I think we share the concern for detainee health. I have read the same articles in the newspaper that you have. I know that this is a priority for the Secretary, so much so that she has a special advisor particularly on detainee health.

I have spoken with her, and she has shared with me her assessment as well as some issues that she sees going forward. During the conversation, I implied to her that, if confirmed and if I assume this office, the Office of Health Affairs will be more than happy to assist her in whatever medical issues she would need guidance on as well as giving her the best science and policy advice available.

Senator AKAKA. Thank you very much.

Dr. GARZA. Thank you, Senator.

Senator AKAKA. Mr. Chairman, my time has expired.

Chairman LIEBERMAN. Thanks, Senator Akaka. Perhaps we will just do a few more questions if my colleagues have them.

Dr. Garza, under Section 516 of the Homeland Security Act, as I read it, the Chief Medical Officer is actually responsible for coordinating all the biodefense activities of the Department. So you would play a very important role, and that is why, if you are confirmed, we will want to work with you—

Dr. GARZA. Yes, sir.

Chairman LIEBERMAN [continuing]. On the legislation that we are going to introduce.

The WMD Commission, Senators Graham and Talent, recommended that we do everything we could to ensure that we had a much more robust response capacity to a biological attack. And I understand you are just going into this, so these are preliminary thoughts, but beyond the upgrading of the biosurveillance that you talked about earlier, what thoughts do you have—this does tie into what Senator Collins mentioned in her opening statement—about our concern, which we share, about the relative lack of capacity to

surge our public health infrastructure in case of a biological or pandemic attack that takes off?

Dr. GARZA. Yes, sir. The Office of Health Affairs is the primary biodefense office within the Department of Homeland Security and so the way that I envision in response to a biodefense or a biological event is, I think, in my priority with building capacity. And so in building capacity, I do not feel that the office should purely focus on surveillance activities and data acquisition and things like this. I believe that the office must take an almost holistic view for all threats, all hazards, as well as working with our component services, such as the Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR), in the response capabilities, as well.

One part where we are particularly effective is in working with our first responders, with our emergency managers, and with law enforcement. Should I be confirmed, I would put emphasis on this office, as well, to get information and guidance, policy directive, down to these individuals, as well, who are going to, frankly, be where the rubber hits the road and the first folks on the scene. They deserve this sort of support from our office.

So I am trying to take more of a systematic approach to our biodefense capabilities with building the structure so that no matter what the threat, whether it is manmade or natural, whether it is a weather-related event or infectious disease or other issues, we would be able to appropriately detect, appropriately respond, and appropriately recover from that event.

Chairman LIEBERMAN. Let me focus finally on H1N1, which we talked about. I think that Secretary Napolitano along with Secretary Sebelius have done an admirable job in both responding and, as importantly—maybe more importantly—keeping the focus on preparing for the flu season to come in the fall. But everybody agrees, we have a lot of work to do, and there are very critical questions about whether, for instance, vaccines will be ready in time.

So I wanted to ask you, assuming you are confirmed, what do you see are the major challenges that we face as a Nation or the Department faces over the next couple of months as we head into the fall and the more traditional flu season to get ready for a possible rapid spread of H1N1?

Dr. GARZA. Yes. I believe everyone on the Committee as well as Secretary Napolitano and myself and the office shares your concerns with H1N1. I know it is a priority of hers. I am familiar with her meeting with Secretary Sebelius and the Department of Education.

So the issues that need to be coordinated before our presumed second surge of the virus are multi-faceted and multi-pronged. And so the issue that we have with OHA, which sort of separates us from the rest of the field, is we have to have better interaction with our partners over at HHS.

I have met with Dr. Lurie at ASPR, talked with the CDC, and sat down and had discussions with Craig Fugate at FEMA, as well, and this seems to be on the top of their list, as well.

So the issue for the Office of Health Affairs would be coordinating with these folks to strengthen our relationships. I know that

we have a physician in our office who is particularly involved with vaccine as well as distribution of vaccine, prioritizing, protecting our workforce, which is on the top of our list, as well as disseminating information down to our critical infrastructure and key resources, as well as our emergency responders, first responders down at the front level, as well as providing guidance to the American people. So all of these issues, I think, put together are issues that the Office of Health Affairs really needs to focus on to get us prepared for the presumed second wave of H1N1.

Chairman LIEBERMAN. Would you say that in the meetings you have had with people at DHS and HHS, for instance, the presumption is that we will have a serious problem with H1N1 this fall and winter, obviously hoping that is not so, but people are going forward acting as if this is going to be a genuine public health crisis?

Dr. GARZA. Thank you, sir. In my meetings with these individuals, they did express to me their concern for the coming fall.

Chairman LIEBERMAN. Right.

Dr. GARZA. They did not expressly say whether they felt it was going to be worse than our spring. Of course, the big fear is that the virus will mutate and assume some sort of different form and then we will be in a lot of trouble. But they did not express with any confidence whether they felt it was going to be worse. So when I was discussing these issues with them, we mostly discussed our needs to better collaborate and work together on H1N1 issues.

Chairman LIEBERMAN. Thank you.

Dr. GARZA. Thank you.

Chairman LIEBERMAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Dr. Garza, earlier this year when we held a hearing with the Secretary to look at the Federal response to the flu pandemic, we found that there was a great debate over whether our border with Mexico should have been closed and also whether there should have been more rigorous screening at the border. Now, I, for one, accept the medical advice we heard that closing the border was not the answer. For one thing, the virus was already in our country.

Dr. GARZA. Yes.

Senator COLLINS. However, I am concerned that the Department seems to be very hesitant to use technology more fully to try to identify travelers who may be carrying H1N1 or some other new communicable disease. Other countries have successfully used technology that is able to scan travelers to identify fever. This was used back when the severe acute respiratory syndrome (SARS) epidemic was in full force, and some countries, including Japan and Singapore, have been using it during the flu pandemic.

What are your views on the use of technology to better screen travelers at the border? After all, I think we have to remember that while our Customs and Border Protection officials and our immigration agents are highly trained, they are not physicians. They are not nurses. They are not health officials.

Dr. GARZA. Yes, Senator. I understand your concerns, and I appreciate them, and I would like to work further with the Committee in order to help with this issue. I know the Secretary keeps this on the top of her list, as well.

So in regard to the border protection, this is of prime importance to the Secretary. It is her responsibility for the protection of the border. I know that she values good, active, actionable intelligence and information in order to decide what actions and what posture she is going to take at the border.

With that being said, I also appreciate the tremendous strain that our Customs and Border Protection agents were under during this event. You are correct, they are not medically trained personnel, and so quite frankly, I think it makes them a little uneasy to be performing duties such as these since they are not medically trained.

So as far as the technology is concerned, I am somewhat familiar with the technology. I cannot say that I am an expert at the technology. But from what I have understood is that it still is not where it needs to be.

Given that, though, I believe the OHA mission should be taking all available resources in order to screen or identify or protect the country from infectious agents and other things coming into the country, and that, of course, includes new technology such as what you were talking about with the thermal scanners. I believe the Office of Health Affairs as well as Science and Technology, we do have a duty to look at, evaluate, and understand all these technologies. It is on the forefront of our agenda every day to protect the people, and it is a priority of the office to make sure that we are using all available resources.

With that being said, I think we should also rely on best science, as well, to dictate what our priorities should be and what equipment we should use and what sort of posture we should take at the border.

Senator COLLINS. The thermal scanners are not perfect, that is certainly true, but they are a tool——

Dr. GARZA. Absolutely.

Senator COLLINS [continuing]. That can be used to screen. It does not mean that you allow that tool to make the decision, and there are, I believe, five developed nations, industrialized nations, using them——

Dr. GARZA. Yes.

Senator COLLINS [continuing]. So clearly there is some value. If they were so inaccurate or unproven——

Dr. GARZA. Right.

Senator COLLINS [continuing]. I doubt very much Japan would be using them. So I really urge you to take a look at this. We need to be willing to use all the tools that we have. Technology should not be used to make the decision, but it can be helpful in assisting individuals who do not have medical training in making the first cut, if you will, in making the preliminary screening more effective.

Similarly, last year, there was a case where a Mexican citizen with a contagious form of resistant tuberculosis was able to cross the border, back and forth, 21 times despite the fact that the Department of Homeland Security had his name and his date of birth. This was an example where the left hand of government did not talk to the right hand of government. The CDC had identified the individual as having this kind of contagious tuberculosis. It was known to the government that, for business reasons, he frequently

crossed the border. And yet there was a failure of communication between the CDC and DHS.

First of all, are you familiar with this case?

Dr. GARZA. I am somewhat familiar. I cannot say I know the intimate details, but yes.

Senator COLLINS. What will you do to make sure that we do not have these egregious gaps in communication? Here, we have an individual who has specifically been identified by the CDC, and there is just poor communication.

Dr. GARZA. Yes. I understand the concern of the Committee with this, and I believe it would be on OHA's priority list to do, as well. But I think what you have brilliantly illustrated is what I was trying to put forth in my opening statement and answers to other questions, and that is capacity and systems building as well as developing relationships with our component services.

So, if confirmed, one of the priorities in my office would be to make sure that those relationships and those systems are robust enough to not let this issue happen again. And if confirmed, I look forward to working with the Border Patrol, CDC, and DHS as a whole so that these sorts of issues would not occur again.

Senator COLLINS. Finally, our Committee held 24 hearings looking at the failed response to Hurricane Katrina. Of all those hearings, the one that stands out most in my mind because it was so tragic and so preventable was the hearing that looked at the number of homebound individuals and elderly, sick individuals in nursing homes who died because of a failure to evacuate them. It was so tragic and so outrageous that it happened.

After that hearing, I had a number of home health care groups with whom I have worked closely come to me and say, we know where the homebound elderly are because we serve them. We visit their homes. But we have never been asked to be involved in evacuation planning.

What will you do to ensure that all resources are brought to bear by States, by local governments, and by the Federal Government to ensure that we never again see homebound elderly individuals who are incapable of evacuating themselves, or people who are in a nursing home who, again, cannot evacuate themselves, become victims of a disaster due to a failure of planning and a failure to mobilize all possible resources?

Dr. GARZA. Yes, Senator. I think that question absolutely goes back to my previous answers of capacity building. And so for us to effectively deal with the entire population, we must make sure that we are cooperating and connected with the entire population, and so that includes populations that you mentioned.

Now, I am not sure if you had a meeting with the FEMA Director right before I did, but that was on the top of his list, as well, when I met with him. And so I do want to assure you that it is on a lot of people's minds. And in particular, Mr. Fugate's direct question to me was, we need better planning on at-risk populations, and I consider the homebound and nursing home population an at-risk population.

I believe that also speaks to the Office of Health Affairs having to think outside the box. We cannot just simply accept the normal response to an event which is very well contained, such as a small

event. We have to be prepared for all hazards, all threats, and all people in response to a catastrophic event.

Senator COLLINS. Thank you. I look forward to working with you.

Dr. GARZA. Thank you.

Senator COLLINS. Thank you, Mr. Chairman.

Chairman LIEBERMAN. Thank you very much, Senator Collins.

I thank you, Dr. Garza. I do not have any further questions, and I think we have reached the limits of the impressive patience of your sons. They have really been very well behaved today. I do not think we should ask more than this of them. [Laughter.]

Dr. GARZA. He almost made it.

Senator COLLINS. A good period on that.

Chairman LIEBERMAN. He expressed a sentiment often felt by people who sit in this room but rarely expressed. [Laughter.]

Without objection, the record will be kept open until noon tomorrow for the submission of any written questions or statements for the record.

It would be the intention of our Committee to have, as we call it, an off-the-floor markup sometime soon of your nomination and hopefully get you confirmed before we break for August recess on August 7.

But I thank you for your willingness to serve. I thank your family for their willingness to back you up as you serve. As Senator Collins said, we really look forward to working with you on these urgent matters of homeland defense. Thanks very much.

Dr. GARZA. Thank you.

Chairman LIEBERMAN. The hearing is adjourned.

[Whereupon, at 11:04 a.m., the Committee was adjourned.]

APPENDIX

**Nomination of Alexander Gerard Garza
to be Assistant Secretary and Chief Medical Officer
Department of Homeland Security**

Chairman Joe Lieberman
July 28, 2009

Good morning. This hearing will now come to order. This morning, the Committee will consider the nomination of Dr. Alexander Gerard Garza to be Assistant Secretary and Chief Medical Officer at the Department of Homeland Security.

This position was created by the Post-Katrina Emergency Management Reform Act of 2006, that was authored, I'm proud to say, by Senator Collins and myself, following this committee's eight-month investigation into why the response of our government to Hurricane Katrina was so poor.

The Post-Katrina Reform Act re-configured FEMA so that it could – for the first time in history – respond really in an excellent way to natural disasters and also beyond that to catastrophic disasters equivalent to the swamping of New Orleans in 2005. Among the new positions it created to achieve end, which was the better protection of the American people in crisis, was the position of Chief Medical Officer, to be the chief and principal advisor to the Secretary of Homeland Security and to the Director of FEMA on both medical and public health issues.

Among the responsibilities of the Chief Medical Officer is coordinating the Department's response to not just natural disasters, but to terrorism, including particularly the threat of bioterrorism, which is a special focus of this Committee in this session, ensuring coordination of all medical preparedness and response activities of the Department, and coordinating the Department's workforce health protection. In short, the Chief Medical Officer is responsible for ensuring that the federal government is ready to carry out a quick, comprehensive and effective medical response to disasters, both natural and unnatural.

I would say it is especially important, and I know the Secretary feels the same way, that this position be filled right away. As chief medical advisor, Dr. Garza, should you be confirmed, you will play a vital role in our nation's response to the H1N1 outbreak, which is continuing. Though many Americans and a lot of the news media have turned to other matters, this epidemic has continued to spread. Cases now number over one million in this country and the flu has not subsided as expected this summer. It has not surged up in numbers, but it has continued at pretty much the same pace, which is not what most public health officials predicted. It continues to be most problematic for children and young adults, and unfortunately there is every indication that it will spread rapidly in the fall, when the traditional flu season returns. Obviously it is imperative that we be ready for that and that we get ready for that and I'm going to ask you about that during the Q and A.

I want to express in closing here my admiration and gratitude for your experience and your service to your country and how much I look forward to hearing your opening statement and then questioning you as you go forward on this nomination.

Statement of
Senator Susan M. Collins

On the Nominations of Dr. Alexander Garza to be
Assistant Secretary for Health Affairs and Chief Medical Officer, Department of Homeland
Security

Committee on Homeland Security and Governmental Affairs July 28, 2009

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Today, the Committee considers the nomination of Dr. Alexander Garza to serve as Chief Medical Officer for the Department of Homeland Security. This position was established in the Post-Katrina Emergency Management Reform Act of 2006 to ensure that the Secretary had expert advice on myriad medical and public health issues.

This Committee's comprehensive investigation into the flawed response to Hurricane Katrina revealed fundamental problems with our nation's preparedness for catastrophic disasters. Our decisions to establish the office of Chief Medical Officer (CMO), to elevate the CMO to the level of Assistant Secretary, and to completely retool the Federal Emergency Management Agency were based on key findings from the Committee's Katrina investigation.

The CMO's responsibilities are significant. They include ensuring the safety of first responders who operate in disaster areas; overseeing the development and deployment of new technology placed in large population areas to detect the release of a biological agent; coordinating with other federal departments and agencies on medical and public health matters such as the H1N1 pandemic; and taking action to ensure that we have plans in place to surge our nation's medical resources in the event of a disaster.

In the coming months, the Chief Medical Officer will play a critical advisory role as the Secretary leads our nation's efforts to deal with the H1N1 outbreak. Some experts fear that H1N1 could return in the fall and winter with higher rates of infection and increased severity.

I am particularly interested in hearing Dr. Garza's thoughts on our ability to surge medical resources to respond to major medical events whether caused by a pandemic flu, the intentional release of a deadly biological agent, or the detonation of a dirty bomb. Last year, this Committee held a series of hearings on our preparedness for the detonation of a 10-kiloton nuclear device and found many gaps in our medical surge capabilities. Dr. Garza brings specific expertise in this area, having served as an emergency doctor in military and civilian settings.

I look forward to Dr. Garza's testimony.

**Senate Homeland Security and Government Affairs Committee
July 28, 2009**

**McCaskill Statement for the Record
Garza Nominations Hearing**

Thank you, Mr Chairman and Ranking Member Collins for this opportunity to introduce Dr. Alex Garza to be Assistant Secretary and Chief Medical Officer of the Department of Homeland Security.

I have known Dr. Garza for over 15 years and am confident in saying that there couldn't be a more qualified person for this position. I first came to know Dr. Garza when he volunteered as the medical expert on a methamphetamine task force I directed as Jackson County Prosecuting Attorney. In recognition of his work he was awarded a Presidential Citation by the Office of National Drug Control Policy.

But his story of service and dedication to the medical community did not start here. Dr. Garza grew up as one of five brothers in Maryland Heights Missouri, a middle class suburb of St. Louis. Being one of five children he learned the valuable art of negotiation at an early age. But more importantly, his mother, who worked the night shift as a nurse in the local emergency department, taught him the value of hard work and serving his community, skills that will serve him well as Assistant Secretary if confirmed.

While attending college he decided he wanted to not just learn from the books, but to experience medicine from the ground up. He delayed attending medical school to work as a paramedic in Kansas City so he could learn from the front lines. He continued his work as a first responder and as a flight medic all through medical school, working weekends and holidays to put himself through school. He graduated from the University of Missouri School of medicine and began the next phase of his emergency medicine training at Truman Medical Center, in Kansas city, Missouri.

On top of all of this, he also heeded to his mother's example to serve by joining the United States Army Reserves medical corp.

He ultimately chose to make his career in medicine about public service when he accepted a position as a member of the faculty at the Truman Medical Center. His tenure was interrupted when he was called to active duty in service of Operation Iraqi Freedom leaving behind his wife, who was in law school at the time, and his then two small children.

Dr. Garza and his team were responsible for rebuilding healthcare in Iraq. What he found were medical schools with out of date textbooks and decades old journals. True to his form, he orchestrated a textbook donation program that led to medical schools from across the United States sending texts to fill the library shelves of schools throughout Iraq.

Because of Dr. Garza's tireless work rebuilding hospitals and clinics he became a trusted member of the Iraqi medical community and developed important strategic relationships. In addition he also cared for an occasional Iraqi sheik, the soldiers in his unit, took his turn at his post and cleared buildings when needed.

When his tour was extended for an additional six months, I consoled Dr. Garza's wife, a long time member of my staff who came to me in tears after learning her husband would be spending Christmas in a bombed out shell of a building where he had volunteered to assist the forward surgical team during a full scale offensive operation in Samarra. He finally made it home to his family and was awarded the Bronze Star as well as the combat action badge.

His career in academics and public service immediately resumed when he returned to Direct Emergency Medical Services for the City of Kansas City and also returned to the faculty at the Truman Medical Center. During this time Dr. Garza recognized that outcomes for cardiac arrest patients could be improved and created a new CPR protocol that challenged conventional dogma. His ability to think outside the box led to a doubling of the survival rate for cardiac arrest patients in Kansas City. For his work he was awarded the Young investigator Award by the American Heart Association. Because of his work, health care workers around the world are now changing the way they resuscitate patients.

Dr. Garza is one of those rare individuals who through hard work and sacrifice has improved the lives of those around him. He has saved the lives of his patients working in the ER, taught compassion and clinical skills to medical students and residents, furthered medical science by publishing numerous articles in peer reviewed scientific journals, served his country at war and improved the way pre-hospital care is rendered across the globe.

It is with great pleasure that I introduce Dr. Alex Garza to the committee. I have every confidence that under his leadership the Office of Health Affairs will serve the Secretary and the President in an effective and meaningful way.

Statement of Alexander Garza
Before the Committee on Homeland Security and Governmental Affairs
United States Senate

on
Nomination to be the Assistant Secretary for Health Affairs and Chief Medical Officer
of the U.S. Department of Homeland Security
July 28, 2009

Good Morning Chairman Lieberman, Ranking Member Collins, and distinguished members of the Committee. I am humbled and honored to be a nominee of President Obama and to seek your support today for my nomination to be Chief Medical Officer (CMO) and Assistant Secretary of the U.S. Department of Homeland Security (DHS).

If I may, Mr. Chairman, I would like to thank my wife Melissa and my sons Alex, Samuel and Daniel for supporting me here today and throughout my career.

I am grateful for the leadership of this Committee for ensuring the Nation is prepared to respond to all hazards and all threats. The position for which I am nominated was authorized by the Post-Katrina Emergency Management Reform Act of 2006. Therefore it is because of the work of this Committee in investigating the government's response to Hurricane Katrina, and the important legislation that all of you championed as a result, that I stand before you today. Thank you for your leadership. If confirmed, I welcome the opportunity to serve as the Chief Medical Officer and Assistant Secretary. I can think of few opportunities to serve that are more tailored to my experiences and education as a first responder, physician, and state and local public health official.

I will briefly outline the experiences and qualifications that have prepared me to lead the Office of Health Affairs (OHA) should I be confirmed. The position of Assistant Secretary and CMO is the principal responsible for medical and health matters in the Department. The role comes with a number of responsibilities, including serving as the principal advisor to the Secretary and Administrator of the Federal Emergency Management Agency (FEMA) on medical and health matters, leading the Department's biodefense and health preparedness activities, and leading a team that provides health and medical expertise throughout DHS and works in collaboration with Federal, State, local, tribal, territorial, and private sector partners.

For the past two decades, I have provided clinical and emergency medical care for the most severely ill and injured in a number of capacities. I began my career in emergency medicine as a paramedic for a high volume, high performance emergency medical services (EMS) systems in Kansas City, Missouri. I worked as an emergency medical technician (EMT), paramedic and flight medic, all before graduating from medical school.

My experiences have given me an education in the capacity, limitations and abilities of our first responders at the local level to respond to disasters of every shape and size. I understand well from first-hand experience that "all disasters are local." As an

emergency department physician, I appreciate that the world of emergency medicine is a microcosm of disaster management. After several years in emergency medicine, I have mastered the ability to quickly synthesize vast quantities of disparate data, prioritize problems, develop a cohesive treatment plan, convey that plan to the team and execute time critical decisions if the best possible outcome for the patient is to occur. If confirmed, these skills will undoubtedly serve me well at DHS.

My professional career includes residency training and board certification in Emergency Medicine, and I rounded out my training by obtaining a Masters Degree in Public Health (MPH). I have held academic appointments at a number of institutions of higher learning including the University of Missouri, the University of New Mexico and Georgetown University Schools of Medicine.

I understand OHA's stakeholder community because I have been on the other side. If confirmed, I will use this perspective and my experience to guide and shape the health and medical policies throughout the vast portfolio of DHS activities including plans, exercises, guidance to stakeholders, and input to DHS' grant programs. I am confident that my clinical and public health expertise will prove invaluable as I provide medical and health advice to the Secretary and FEMA Administrator.

In addition to my civilian accomplishments in public health, I have spent the last 10 years as a public health officer and team chief at battalion and command levels with the U.S. Army Special Operations Command. While serving as the public health team chief for the 418th Civil Affairs Battalion, I deployed to Iraq in 2003. I will bring this Federal experience with me to DHS if confirmed.

Furthermore if confirmed, I will apply the same lessons learned from leading a large EMS agency and serving as the medical advisor to a battalion commander on the battlefield: lead from the front, develop a strategy using all available information, convey your intent to your team, and allow them to develop the most effective way to execute your intent. This reflects how I intend to manage the Office of Health Affairs if confirmed. OHA is made up of many talented professionals including physicians, nurses, epidemiologists, veterinarians, microbiologists and many more, who share my passion for public service. As the leader of the office, it will be my role, if confirmed, to clarify the mission, challenge, inform and motivate my team, and ensure that all of OHA's customers, including DHS leadership, components and employees, the congress, state, local and private sector stakeholders, and the public at large, receive the medical and public health support necessary to execute our shared mission of protecting our great nation

My vision for OHA is to provide the DHS Secretary and the FEMA Administrator with sound medical advice founded in the best science available. My priorities for the office if confirmed include: Ensuring adequate medical and health surveillance and assisting in the response to catastrophic events, protecting the health of the DHS workforce, and building resilience within the American people to be prepared for all-hazards. For example, I would like to engage our partners to increase biosurveillance data, ensure the

accuracy of our data sources, and push products to our customers that fully meet their needs. Given the current environment, my initial operational focus if confirmed will be to engage fully in H1N1 preparations, including coordination with DHS' external partners and a particular focus on component services, such as personal protective equipment for those on the front lines. If confirmed, I would ensure that OHA effectively achieves its mission, while working efficiently to best use taxpayer dollars, practicing transparency, and collaborating with stakeholders including those within DHS, in the interagency, and local, state, tribal, and territorial governments.

In closing, I am honored by the President's and Secretary Napolitano's faith in my ability to effectively lead this organization, and would like to put my knowledge and experience to use in continued service to my country. I look forward to working with this Committee if confirmed and I am glad to answer any questions you may have.

BIOGRAPHICAL AND FINANCIAL INFORMATION REQUESTED OF NOMINEES

A. BIOGRAPHICAL INFORMATION

1. **Name:**
 - Alexander Gerard Garza
2. **Position to which nominated:**
 - Assistant Secretary of Homeland Security and Chief Medical Officer, Department of Homeland Security
3. **Date of nomination:**
 - July 7, 2009
4. **Address:**
 - Home: REDACTED
 - Office: Washington Hospital Center, Department of Emergency Medicine, 110 Irving Street NW, Washington, DC 20010
5. **Date and place of birth:**
 - September 10, 1967; St. Louis, Missouri
6. **Marital status: (Include maiden name of wife or husband's name.)**
 - Married to Melissa Hope Garza (Heiman)
7. **Names and ages of children:**
 - REDACTED
 -
 -
8. **Education: List secondary and higher education institutions, dates attended, degree received and date degree granted.**
 - Masters in Public Health - St. Louis University School of Public Health, St. Louis, Missouri, August 1999–January 2003; January 2003

- Chief Resident/Clinical Instructor in Emergency Medicine - Department of Emergency Medicine, Truman Medical Center, University of Missouri - Kansas City School of Medicine, Kansas City, Missouri, July 1998–July 1999; July 1999
- Post Graduate Residency Training in Emergency Medicine – Department of Emergency Medicine, Truman Medical Center, University of Missouri - Kansas City School of Medicine, Kansas City, Missouri, July 1996–June 1999; June 1999
- Doctor of Medicine – University of Missouri – Columbia School of Medicine, Columbia, Missouri, August 1992–May 1996; May 1996
- Bachelor of Science in Biology – University of Missouri - Kansas City, Kansas City, Missouri, January 1986–July 1990; July 1990
- Paramedic Certification – Penn Valley Community College, Kansas City, Missouri, September 1989–May 1990; May 1990
- St. Thomas Aquinas High School – Florissant, Missouri, 1981-1985; May 1985

9. Employment record: List all jobs held since college, and any relevant or significant jobs held prior to that time, including the title or description of job, name of employer, location of work, and dates of employment. (Please use separate attachment, if necessary.)

- Associate Professor (Pending)/Research Director, Department of Emergency Medicine, Georgetown University School of Medicine, Washington DC, April 2007–Present
- Staff Physician, Washington Hospital Center, Department of Emergency Medicine, Washington, DC, April 2007-present
- Director of Military Programs, ER One Institute, Department of Emergency Medicine, Washington Hospital Center, Washington, DC, April 2007–present
- Assistant Professor of Emergency Medicine, Department of Emergency Medicine, University of New Mexico School of Medicine, Albuquerque, NM, July 2006–April 2007
- Assistant Professor of Emergency Medicine and Staff Physician, Department of Emergency Medicine, Truman Medical Center, University of Missouri-Kansas City School of Medicine, Kansas City, Missouri, July 1999–July 2006
- Rotary Wing Flight Paramedic, Staff for Life Helicopter Service, University of Missouri – Columbia Hospitals and Clinics, Department of Emergency Medical Services, Columbia, Missouri, 1993–1996

- Paramedic (Ground Services), Metropolitan Ambulance Services Trust (MAST) Kansas City, Missouri, 1989–1996

10. Government experience: List any advisory, consultative, honorary or other part-time service or positions with federal, State, or local governments, other than those listed above.

- Associate Medical Director, Emergency Medical Services, State of New Mexico Department of Health, Santa Fe, NM July 2006-April 2007
- Medical Director, Emergency Medical Services, Kansas City Missouri Health Department, January 2005–July 2006
- Medical Director, Missouri State EMS Region A, January 2005–July 2006
- Associate Medical Director, Emergency Medical Services, Kansas City Missouri Health Department, Kansas City, Missouri, July 1999–January 2005
- Medical Director, Kansas City International Airport Police Dept/AED program, Kansas City, Missouri. July 1999–January 2005
- Medical Director, Federal Reserve Bank of Kansas City Protection Force/AED program, Kansas City, Missouri. July 1999–January 2003
- State of Missouri – 911 Oversight Advisory Board, Gubernatorial Appointment, February 2000–March 2003
- Emergency Physicians EMS Advisory Board (EPAB), Kansas City, Missouri Health Department, Kansas City, Missouri. July 1999–July 2001
 - EMS Clinical Upgrade Subcommittee, Chairman, July 1999–Jan 2005
 - EMS Protocol Committee, Chairman, July 1999–Jan 2005
 - EMS Dispatch Committee, January 2001–July 2006
- United States Army Reserve, United States Army Medical Corp/United States Civil Affairs and Psychological Operations, MAJOR (O-4), 62A, Direct Commission – May 5, 1997

USAR -TPU Assignments –

- United States Army Civil Affairs and Psychological Operations Command (USACAPOC), United States Army Special Operations Command (USASOC)
 - Preventative Medicine Officer (60C), Public Health Team Physician, 352 Civil Affairs Command, Ft. Meade, MD, June 2007 – present

- Preventative Medicine Officer (60C), Public Health Team Chief and Battalion Surgeon, 418th Civil Affairs Battalion, Belton, Missouri, June 2001 – June 2007
- Instructor, Military and Emergency Medicine (MEM, Uniformed Services University of Health Sciences (USUHS), Bethesda, MD, October 2008-Present
- Emergency Physician (62A), 4204 US Army Hospital, Topeka, Kansas, 1997 – 2001

Deployments:

- Operation Flintlock, June 6-20, 2005, Dakar, Senegal
Public Health Team Chief – Public Health Team Chief for the 418th Civil Affairs Battalion, attached to the 1/10 Special Forces Group (Airborne), Joint Special Operations Task Force (JSOTF)
- Operation Iraqi Freedom I, January 2003 – April 2004, Salah al Din Province, Iraq
 - Public Health Team Chief – Public Health Team Chief for the 418th Civil Affairs Battalion, in support of 4th Infantry Division (Mechanized)
 - Battalion Surgeon – Served as battalion surgeon for the 418th Civil Affairs Battalion providing medical care to 150 soldiers for deployment readiness, combat operations and redeployment to the United States. Clinical instruction and lectures in health issues for battalion personnel
- Special Investigator, September 2003, Medical expert for MG Raymond Odierno, Commander, Fourth Infantry Division (M) performing internal investigations involving medical care of prisoners within the 4th Infantry Division (M) area of operations
- Iraqi Medical Book Donation Program, January 2003-April 2004, Coordinated with WebMD/Medscape to produce website for donation of medical books to Iraq. To date over 1 million books and journals have been delivered to medical colleges in Iraq.

11. Business relationships: List all positions currently or formerly held as an officer, director, trustee, partner, proprietor, agent, representative, or consultant of any corporation, company, firm, partnership, or other business enterprise, educational or other institution.

- Medical Consultant, FirstWatch Inc, San Diego, CA, June 2007–present
- Medical Consultant, Logical Images Inc., Rochester, NY, February 2007–present
- Medical Consultant, Cox Health Care Systems, Springfield, MO, November 2005

- Medical/Legal Consultant, Baer and Lashley LLC, St. Louis, MO, 2005
- AMG Technologies; partner, Kansas City, MO; 2005-2006
- Emergency Medical Service Consulting, LLC; sole proprietor; Albuquerque, New Mexico and now licensed in Falls Church, Virginia; 2006-present

12. Memberships: List all memberships, affiliations, or and offices currently or formerly held in professional, business, fraternal, scholarly, civic, public, charitable or other organizations.

- US Civil Affairs Association 2004–present
- Special Operations Medical Association 2002–present
- American Public Health Association 2002–present
- Missouri Emergency Medical Services Assoc. 2001–2006
- Society for Academic Emergency Medicine 1999–present
- National Flight Paramedics Association 1996–1998
- American College of Emergency Physicians 1992–present
- American Medical Association 1992–2005
- Emergency Medicine Residents Association 1992–1999

- Co-Director and Founder, Emergency Department Evidence Based Medicine Program, Department of Emergency Medicine Residency Program, Truman Medical Center, University of Missouri-Kansas City School of Medicine, July 2002 to July 2006

- Co-Director and Founder, Evidence Based Emergency Medicine Journal Club, Department of Emergency Medicine Residency Program, Truman Medical Center, University of Missouri-Kansas City School of Medicine, July 2002 to July 2006

- American College of Emergency Physicians – Missouri Chapter
 - Member, 1992 - 2006
 - Councilor, August 2005 – June 2006
 - Executive Board Member, July 2001-January 2003
 - Grant Reviewer, June 2000 to January 2003

- Emergency Physicians Foundation of Kansas City
 - President, 2001 to 2003
 - Secretary – Treasurer, July 1999 – 2001
 - Member, July 1999-2006

- Hospital Committees – Truman Medical Center
 - Disaster Committee, March 2005 – July 2006

- ICU Committee, July 2004 – July 2006
- Trauma Quality Care Committee, July 1999 – January 2003
- Trauma Research Committee, July 1999 – July 2001
- National Association of EMS Physicians
 - Member, 2000 – Present
 - Quality Improvement Committee – Chairman, Jan 2009 – present, R
 - Research Committee, January 2001 – 2008
- Prehospital Emergency Care, Manuscript Peer Reviewer, 2001 – present
- Society for Academic Emergency Medicine, Abstract Reviewer, 2007- present
- MidAmerica Fusion Center or Kansas City Terrorism Early Warning Group (TEW), Founding Member and Principal Advisor for Emergency Medical Services and Public Health, 2005-2006

13. Political affiliations and activities:

- (a) **List all offices with a political party which you have held or any public office for which you have been a candidate.**
- None
- (b) **List all memberships and offices held in and services rendered to any political party or election committee during the last 10 years.**
- None
- (c) **Itemize all political contributions to any individual, campaign organization, political party, political action committee, or similar entity of \$50 or more during the past 5 years.**

Democratic Senate Campaign Committee	\$100.00	2008
Claire McCaskill	\$300.00	2006
Claire McCaskill	\$1,200.00	2004
Jamie Metzl	\$250.00	2004
Jamie Metzl	\$ 250.00	2004
Claire McCaskill	\$ 500.00	2004

14. Honors and awards: List all scholarships, fellowships, honorary degrees, honorary society memberships, military medals and any other special recognitions for outstanding service or achievements.

- Clinical Teacher of the Year, Georgetown University School of Medicine/ Washington Hospital Center, Department of Emergency Medicine, May 2009
- Outstanding Young Physician Alumni Award, University of Missouri School of Medicine, May 2008
- Young Investigator Award, American Heart Association, November 2007
- Frank Mitchell Emergency Medical Services Physician of the Year, Missouri Emergency Medical Services Association, September 2006
- Distinctive Service Award, University of Missouri, Kansas City School of Medicine, 1998
- Resident of the Year, Department of Emergency Medicine, Truman Medical Center, University of Missouri – Kansas City School of Medicine, 1999
- White House Commendation, Commendation for Drug Demand Reduction, 1999
- Military Awards and Decorations
 - Army Achievement Medal 2006
 - Combat Action Badge 2005
 - Overseas Training Ribbon 2005
 - Meritorious Unit Citation 2005
 - Valorous Unit Award 2005
 - Bronze Star Medal for Meritorious Service 2004
 - Army Commendation Medal 2004
 - Iraq Campaign Ribbon 2004
 - Global War on Terrorism Expeditionary Medal 2004
 - Global War on Terrorism Service Medal 2004
 - Army Reserve Medal with M device 2004
 - National Defense Medal 2003
 - Army Service Ribbon 1997

15. Published writings: Provide the Committee with two copies of any books, articles, reports, or other published materials which you have written.

Book Chapters

I do not own a copy of *Geriatric Emergency Medicine* and the topic of the article is not relevant to the position for which I am nominated. I do have a copy of *Emergency Medicine: Just the Facts*, and the chapters I wrote are attached.

- Garza AG: Anemia in the Elderly. In Ma OJ (ed). *Geriatric Emergency Medicine*. McGraw-Hill, Inc., 2003

- Garza AG: Thermal Burns. In Cline D, Ma OJ (eds): *Emergency Medicine: Just the Facts*. McGraw-Hill, Inc., 2000.
- Garza AG: Arthropod Bites and Stings. In Cline D, Ma OJ (eds): *Emergency Medicine: Just the Facts*. McGraw-Hill, Inc., 2000.
- Garza AG: Peripheral Neurologic Disorders. In Cline D, Ma OJ (eds): *Emergency Medicine: Just the Facts*. McGraw-Hill, Inc., 2000.
- Garza AG: Reptile Envenomation. In Cline D, Ma OJ (eds): *Emergency Medicine: Just the Facts*. McGraw-Hill, Inc., 2000.

Abstracts

- Garza AG, Levy M. "Time to Coronary Artery Dilation Differences in EMS vs. Self Transport to Hospital." Prehospital Emergency Care; January 2009.
- Garza AG, Gratton MC, Salomone JS, McElroy J, Lindholm DL. "Environmental Factors Do Not Affect Out of Hospital Intubation Success." Prehospital Emergency Care; January 2009.
- Garza AG, Gratton MC, Salomone JS, McElroy J, Lindholm DL. "Ten Years of Paramedic Witnessed Cardiac Arrest: Who are the Survivors." Prehospital Emergency Care; January 2009.
- Garza AG, Dean S. "EMS Syndromic Surveillance Strategies in Disasters: On the Ground Focused Analysis." American Public Health Association; October 2008.
- Garza AG, Gratton MC, Salomone JS, Lindholm D, McElroy J. "Time Accumulation in EMS Response to Presumed Cardiac Arrest Patient." European Journal of Emergency Medicine; September 2008.
- Garza AG, Gratton MC, Salomone JS, Lindholm D, McElroy J. "Improvement in Survival to Discharge in Pulseless Electrical Activity Patients Using Near Continuous Chest Compressions" Academic Emergency Medicine; May 2008.
- Garza AG, Gratton MC, Lindholm D, McElroy J. "Quality Improvement Program Decreasing Trauma Scene Time" Prehospital Emergency Care; January 2008.
- Garza AG, Gratton MC, Lindholm D, McElroy J. "Factors influencing Increased Trauma Scene Time" Prehospital Emergency Care; January 2008.
- Garza AG, Gratton MC, Salomone J, Lindholm D, McElroy J. "Improvement in Survival of Out of Hospital Cardiac Arrest Using a Novel Resuscitation Algorithm" Prehospital Emergency Care; January 2008.

- Garza AG "Using Normal EMS Emergencies as Surrogates for Situational Awareness Programs on Out of Hospital Data" International Society for Disease Surveillance; October 2007.
- Garza AG, Gratton MC, Salomone J, Lindholm D, McElroy J. "Improvement in Survival of Out of Hospital Cardiac Arrest Using a Novel Resuscitation Algorithm" *Circulation*, November 2007.
- Garza AG, Gratton MC, Salomone J, Lindholm D. "Improvement in Out of Hospital Cardiac Arrest Return of Spontaneous Circulation Using a Novel Resuscitation Algorithm" *American Journal of Emergency Medicine*, Sept 2007.
- Garza AG, Gratton MC, McElroy J, Lindholm D. "Environmental Factors Predicting Intubation Failure in Out of Hospital Cardiac Arrest Patients" *Annals of Emergency Medicine*, September 2006.
- Garza AG, Gratton MC, McElroy J, Lindholm D. "Intubation by Out of Hospital Providers Increases Mortality in Patients with Ventricular Fibrillation" *Annals of Emergency Medicine*, September 2006.
- Garza AG, Gratton MC, McElroy J. "Cardiac Arrest Time Intervals Using a Single Time Standard". *Academic Emergency Medicine*, May 2005.
- Garza AG, Gratton MC, McElroy J. "Environmental Factors Affecting Intubation Success in Adult Out of Hospital Cardiac Arrest Patients" *Academic Emergency Medicine*, May 2005.
- Garza AG, Gratton MC, McElroy J: "Does EMS dispatch predict acuity as measured by red lights and siren return to hospital" *Prehospital Emergency Care*, Jan 2005.
- Garza A, Gratton MC, Algren A. "Risk of prehospital intubation failure among traumatically injured and pediatric patients compared to adult cardiac arrest" *Prehospital Emergency Care*, Jan 2003.
- Garza A, Gratton MC, Coontz DC, Noble E. "Paramedic oral endotracheal intubation; does experience matter?" *Prehospital Emergency Care*, Jan 2001.
- Garza A, Gratton MC, Carlson BC. "The ability of paramedic EMS dispatchers to accurately diagnose cardiac arrest". *Academic Emergency Medicine*, May 2001
- Seaman S, Gratton MC, Garza A. "Out of Hospital assessment of Stroke" *Annals of Emergency Medicine*, 2000;36(4); S38.
- Gratton M, Hassen J, Gaddis G, Garza A. "Prospective Determination of Paramedic Ability to Appropriately Triage Destination for Alcohol-Intoxicated

Patients Using Standardized Criteria" *Annals of Emergency Medicine*, 2000;36(4);S18.

Peer Reviewed Scientific Papers

- Garza AG, Gratton MC, Salomone JS, Lindholm D, McElroy J, Archer R. "Improved Patient Survival Using a Modified Resuscitation Protocol For Out-of-Hospital Cardiac Arrest". *Circulation*; May 15, 2009;119.
- Garza AG, Gratton MC, McElroy J. "Environmental Factors in Out of Hospital Intubation of Cardiac Arrest Patients" *Prehospital Emergency Care*, July 2008.
- Garza AG, Gratton MC, McElroy J. "Does EMS dispatch predict acuity as measured by red lights and siren returns to hospital" *Prehospital Emergency Care*, January 2007;12(1):24-30.
- Garza AG, Gratton MC, Algren A, Ma OJ. "Risk of intubation non attempt and failure in pediatric and trauma patients compared to adult cardiac arrest" *Prehospital Emergency Care*. April 2005; 9(2): 163-166.
- Garza AG, Wyrwich K, "Health Utilities and the Standard Gamble." *Academic Emergency Medicine*, April 2004;10(4)
- Garza AG, Gratton MC, Coontz DC, Noble E. "Effect of Paramedic Experience on Orotracheal intubation Success Rates" *American Journal of Emergency Medicine*. Oct 2003; 5(3): 251-256.
- Garza AG, Gratton MC, Carlson BC. "The accuracy of predicting cardiac arrest by Emergency Medical Services Dispatchers: the calling party effect" *Academic Emergency Medicine*, September 2003; 10(9):955-960.
- Steele MT, Westdorp EJ, Garza AG, Watson WA, Ma OJ. "The incidence of stimulant abuse among adult emergency department seizure patients". *Journal of Clinical Toxicology*: 2000; 38(6).609-613.

Other Publications

- Garza AG: "Lost Smiles Recovered". *Academic Emergency Medicine*: 2004; 18(8).891-892.

16. Speeches:

- (a) **Provide the Committee with two copies of any formal speeches you have delivered during the last 5 years which you have copies of and are on topics relevant to the position for which you have been nominated. Provide copies of any testimony to Congress, or to any other legislative or administrative body.**

- While I have made no formal speeches with the exception of the one below, I am including a list of lectures and presentations I provided over the past 5 years.

Speeches

- Midwest Trauma Society Annual Meeting, Invited Speaker, Weapons of Mass Destruction – Are We Ready? Kansas City, MO, May 2005

Presentations – Many of the presentations listed below are abstracts listed above in my response to question 15 that were presented at conferences.

- National Association of EMS Physicians, Garza AG, Levy M., “Time to Coronary Artery Dilation Differences in EMS vs. Self Transport to Hospital,” Jacksonville, FL, Jan 2009.
- National Association of EMS Physicians, Garza AG, Gratton MC, Salomone JS, McElroy J, Lindholm DL., “Environmental Factors Do Not Affect Out of Hospital Intubation Success,” Jacksonville, FL, Jan 2009.
- National Association of EMS Physicians, Garza AG, Gratton MC, Salomone JS, McElroy J, Lindholm DL., “Environmental Factors Do Not Affect Out of Hospital Intubation Success,” Jacksonville, FL, Jan 2009.
- National Association of EMS Physicians, Garza AG, Gratton MC, Salomone JS, McElroy J, Lindholm DL., “Ten Years of Paramedic Witnessed Cardiac Arrest: Who are the Survivors,” Jacksonville, FL, Jan 2009.
- American Public Health Association, Garza AG, Dean S. “EMS Syndromic Surveillance Strategies in Times of Disaster: On the Ground Focused Analysis,” San Diego, CA, Oct 2008.
- European Society for Emergency Medicine, Garza AG, Gratton MC, Salomone JS. “Time Accumulation in EMS Response to Presumed Cardiac Arrest Patients” European Society for Emergency Medicine, Munich, Germany Sept 2008.
- National Association of EMS Physicians, Garza AG, Gratton MC, Lindholm DA, McElroy J, Newland B., “Quality Improvement Program Decreasing Trauma Scene Time,” Phoenix, AZ, January 2008.
- National Association of EMS Physicians, Garza AG, Gratton MC, Lindholm D, McElroy J., “Factors influencing Increased Trauma Scene Time,” Phoenix, AZ, January 2008.

- National Association of EMS Physicians, Garza AG, Gratton MC, Salomone J, Lindholm D, McElroy J., "Improvement in Survival of Out of Hospital Cardiac Arrest Using a Novel Resuscitation Algorithm," Phoenix, AZ, January 2008.
- American Heart Association Resuscitation Science Symposium, Garza AG, Gratton MC, Salomone JS, Lindholm D, McElroy J, Archer R., Oral Presentation "Best of the Best," "Improvement in Out of Hospital Survival to Discharge Using a Novel Resuscitation Algorithm," Orlando, FL, November 2007.
- Mediterranean Emergency Medicine Conference, Garza AG, Gratton MC, Salomone J, Lindholm D. "Improvement in Out of Hospital Return of Spontaneous Circulation Using a Novel Resuscitation Algorithm," Sorrento, Italy Sept 2007.
- American College of Emergency Physicians, Garza AG, Gratton MC, McElroy J, Lindholm D., "Environmental Factors Predicting Intubation Failure in Out of Hospital Cardiac Arrest Patients," New Orleans, LA, October 2006.
- American College of Emergency Physicians, Garza AG, Gratton MC, McElroy J, Lindholm D., "Intubation by Out of Hospital Providers Increases Mortality in Patients with Ventricular Fibrillation," New Orleans, LA, October 2006.
- University of Missouri-Columbia School of Medicine, Invited Speaker – Physician alumni weekend, Medical Care and Education in Iraq, October 20, 2006
- Society for Academic Emergency Medicine, Garza AG, Gratton MC, McElroy J., "Cardiac Arrest Time Intervals Using a Single Time Standard," New York, NY, May 2005.
- Society for Academic Emergency Medicine, Garza AG, Gratton MC, McElroy J., "Environmental Factors Affecting Intubation Success in Adult Out of Hospital Cardiac Arrest Patients," New York, NY, May 2005.
- National Association of EMS Physicians, Gratton MC, Garza AG, McElroy J., Poster Presentation: "Accuracy of dispatch determinants to predict acuity as measured by red lights and siren return to the hospital," Naples, FL, January 2005.
- Invited Speaker, 325th Field Hospital, Role of Medicine in Civil Military Operations, Independence, MO, October 2005.

- Kansas City Missouri Health Department, Invited Speaker – Cardiac Arrest Symposium, Current research in out of hospital cardiac arrest resuscitation, Kansas City, MO, October 2005.
 - St. Louis University School of Public Health, Invited speaker, “Medical Care and Education in post war Iraq”, St. Louis, MO, October 2005.
 - Invited Speaker, 89th Regional Readiness Command Medical Symposium, “Role of Medicine in Civil Military Operations,” Kansas City, MO, September 2005.
 - Midwest Trauma Society Annual Meeting, Invited Speaker, Weapons of Mass Destruction – Are We Ready?, Kansas City, MO, May 2005.
 - Sunrise Health Systems, Invited Speaker Trauma Grand Rounds, “Medical care and Education in Iraq”, Las Vegas, NV, September 2004.
 - Missouri Combined Clinical Conference, Invited Speaker, “Medical Care and Education in Iraq”, Lake of the Ozarks, MO, September 2004.
 - Kansas City Missouri Health Department, Invited Speaker, “Medical care and education in Post war Iraq”, Kansas City, MO, June 2004.
- (b) **Provide a list of all speeches and testimony you have delivered in the past 10 years, except for those the text of which you are providing to the Committee. Please provide a short description of the speech or testimony, its date of delivery, and the audience to whom you delivered it.**
- While I have made no formal speeches and testimonies, I am including a list of lectures and presentations I have provided over the past 10 years.
 - Medical Librarians Association, Invited speaker, “Iraqi Medical Care and Education, Anatomy of Neglect”, Washington DC, May 2004.
 - National Association of EMS Physicians, Garza AG, Gratton MC, Algren A., Poster Presentation: “The risk of intubation failure in pediatric and traumatically injured patients compared to medical cardiac arrest,” Panama City, FL, January 2003.
 - Invited Speaker, St. Vincent’s Mercy Hospital, Department of Emergency Medicine, Toledo OH, October 2001.
 - Combined Clinical Conference, Oral Presentation “Prehospital Airway Control,” Lake of the Ozarks, Missouri, August 2001.

- Society for Academic Emergency Medicine, Garza AG, Carlson BS, Gratton MC., Oral presentation: "The ability of paramedics to accurately dispatch cardiac arrest," Atlanta, Georgia, May 2001.
- National Association of EMS Physicians, Garza AG, Gratton MC, Coontz D, Noble E., Poster presentation "Paramedic Oraltracheal Intubation: Does experience matter?" Sanibel Island, Florida. January 2001.
- American College of Emergency Physicians Scientific Assembly, Poster presentation "Out of hospital assessment of Stroke," Seaman S, Gratton M, Garza AG, Philadelphia, Pennsylvania. October 2000.
- American College of Emergency Physicians Scientific Assembly, Poster presentation "Prospective Determination of Paramedic Ability to Appropriately Triage Destination for Alcohol-Intoxicated Patients Using Standardized Criteria," Gratton M, Hassen J, Gaddis G, Garza AG., Philadelphia Pennsylvania. October 2000.
- Society for Academic Emergency Medicine, Garza AG, Steele MT, Westdorp EJ, Ma OJ, Watson WA, Poster presentation "Incidence of stimulant abuse among adult ED seizure patients" Boston, Massachusetts. March 1999
- I have made presentations for Department of Emergency Medicine, Truman Medical Center/University of Missouri Kansas City School of Medicine on the following topics:
 - Advanced airway management;
 - Toxicologic Emergencies
 - Diabetic Emergencies
 - Environmental emergencies
 - Carbon monoxide poisoning
 - Dermatologic emergencies
 - Medical management of biological warfare casualties
 - Firearm Injuries
 - Pericarditis and Endocarditis
 - Medical effects of methamphetamine
 - Prehospital termination of resuscitation
 - Evidenced Based Medicine
 - Biostatistics
 - Mechanisms and Physics of Injury Patterns
 - Hypersensitivity Reactions
- I have made presentations for classes in the Masters program in Public Health at the St. Louis University School of Public Health.

17. Selection:

(a) Do you know why you were chosen for this nomination by the President?

I believe the President and Secretary Napolitano value my extensive government and military public health expertise. I believe they trust me to deliver a coordinated, quick and effective response. Additionally, I believe they value my ability to not only understand policy but also implement this in the field. I bring expertise, leadership and passion to this essential position. My experience with people in need, troops on the ground, EMS professionals in the field, doctors in the hospitals, regional state and federal officials their language and can anticipate their needs and convey them as a layperson or a scientists in the time of need to get the best outcome possible.

(b) What do you believe in your background or employment experience affirmatively qualifies you for this particular appointment?

The Office of Health Affairs is charged with overseeing a spectrum of health related issues and their relation to national security. My credentials are broad, flexible and make me uniquely qualified for this position. My experiences cover a wide spectrum including being a clinician and academician in emergency and disaster medicine as well as public health. I further have significant expertise in administration, operational/contingency planning and tactical execution on the ground. I am board certified in Emergency Medicine with over 10 years of experience on the front lines serving in academic emergency departments and Level I trauma centers across the country caring for the most severely injured and ill. Facing front page medical issues on a daily basis has given me first-hand knowledge of our health systems and emergency response challenges. As a clinical educator I have taught hundreds of young physicians in the science and art of emergency medicine, public health and emergency medical systems. As an academician I understand how only with the use of rigorous scientific exploration can we improve upon the delivery of response, medical care and disaster planning for the population. I have lectured and presented original research at numerous national and international scientific meetings, published multiple manuscripts in scholarly journals and edited textbooks and online content in emergency medicine, out of hospital care and disaster medicine. I understand how important it is to develop, implement and execute best practices in the field. Coupled with my Masters Degree in Public Health, I furthermore understand the larger picture implications for the population regarding our response to emergencies and contingency planning.

As a medical director of high performance emergency medical services systems. I have an unqualified understanding of the capabilities and inner workings of our emergency response systems and "street credibility" that comes with my years as a ground and flight paramedic. I understand what it takes to get systems functioning and able to respond in a crisis.

Perhaps the most powerful of my experiences was the year I spent in Iraq as a public health team chief on a US Army Special Operations Civil Affairs team. During this time, I worked to rebuild the medical infrastructure and strengthen the medical education system, and I developed a deep understanding of operational planning and tactical operations in austere conditions. I also deployed to Africa with a Special Forces Joint Operations Task Force, working with host country personnel on medical issues and joint training. This experience in the military gives me a unique understanding of international medicine and how this affects global security and international relationships as well as valuable experience in the workings of our partners in the Department of Defense and United States Agency for International Development. In addition, I have been a consultant on biosurveillance for the leading company in out of hospital surveillance; FirstWatch Inc. I have unique understandings of electronic data surveillance and situational awareness related to disease monitoring. I was a founding member and principal advisor for Emergency Medical Services and Public Health of the Midwest Fusion Center or Terrorism Early Warning Group (TEW) working with our partners in law enforcement and fire suppression as well as other governmental entities in the analysis of disparate data to produce situational awareness measures within our area.

I believe that all of these life experiences combined with my formal education make me an excellent candidate, capable of executing the duties associated with this position.

B. EMPLOYMENT RELATIONSHIPS

1. Will you sever all connections with your present employers, business firms, business associations or business organizations if you are confirmed by the Senate?

I will resign as an employee physician and independent consultant; however, because I believe it is important for me to maintain my medical skills, I will seek authorization from the Department of Homeland Security to volunteer as an emergency physician for up to eight hours a month on my personal time at Washington Hospital Center (WHC) as my schedule permits. Moreover, this volunteer service will enable me to interact with our front line workers to keep me and our offices abreast of issues related to the delivery of medical care. I have received preliminary approval from DHS's designated agency ethics official to volunteer in this capacity.

2. Do you have any plans, commitments or agreements to pursue outside employment, with or without compensation, during your service with the government? If so, explain.

- No
3. Do you have any plans, commitments or agreements after completing government service to resume employment, affiliation or practice with your previous employer, business firm, association or organization, or to start employment with any other entity?
 - No
 4. Has anybody made a commitment to employ your services in any capacity after you leave government service?
 - No
 5. If confirmed, do you expect to serve out your full term or until the next Presidential election, whichever is applicable?
 - Yes
 6. Have you ever been asked by an employer to leave a job or otherwise left a job on a non-voluntary basis? If so, please explain.
 - No

C. POTENTIAL CONFLICTS OF INTEREST

1. Describe any business relationship, dealing or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.
 - In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Homeland Security's designated agency ethics official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department's designated agency ethics official. I am not aware of any other potential conflicts of interest.
2. Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any legislation or affecting the administration or execution of law or public policy, other than while in a federal government capacity.
 - None
3. Do you agree to have written opinions provided to the Committee by the designated agency ethics officer of the agency to which you are nominated and by the Office of

Government Ethics concerning potential conflicts of interest or any legal impediments to your serving in this position?

- Yes

D. LEGAL MATTERS

1. Have you ever been disciplined or cited for a breach of ethics for unprofessional conduct by, or been the subject of a complaint to any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, provide details.
 - No
2. Have you ever been investigated, arrested, charged or convicted (including pleas of guilty or nolo contendere) by any federal, State, or other law enforcement authority for violation of any federal, State, county or municipal law, other than a minor traffic offense? If so, provide details.
 - No
3. Have you or any business of which you are or were an officer, director or owner ever been involved as a party in interest in any administrative agency proceeding or civil litigation? If so, provide details.
 - No
4. For responses to question 3, please identify and provide details for any proceedings or civil litigation that involve actions taken or omitted by you, or alleged to have been taken or omitted by you, while serving in your official capacity.
 - N/A
5. Please advise the Committee of any additional information, favorable or unfavorable, which you feel should be considered in connection with your nomination.
 - None

E. FINANCIAL DATA

All information requested under this heading must be provided for yourself, your spouse, and your dependents. (This information will not be published in the record of the hearing on your nomination, but it will be retained in the Committee's files and will be available for public inspection.)

REDACTED

AFFIDAVIT

Alexander Gerard Garza being duly sworn, hereby states that he/she has read and signed the foregoing Statement on Biographical and Financial Information and that the information provided therein is, to the best of his/her knowledge, current, accurate, and complete.

Alexander Garza

Subscribed and sworn before me this 13th day of July, 2009

Jared Vincent Ferris

Notary Public



Jared Vincent Ferris
Notary Public, District of Columbia
My Commission Expires 12-14-2009

**U.S. Senate Committee on Homeland Security and Governmental Affairs
Pre-hearing Questionnaire for the Nomination of Alexander G. Garza to be
Assistant Secretary (Health Affairs) and Chief Medical Officer at
The Department of Homeland Security**

I. Nomination Process and Background

1. Why do you believe the President nominated you to serve as the Assistant Secretary to head the Office of Health Affairs and Chief Medical Officer (CMO) for the Department of Homeland Security ("DHS" or "the Department")?

I believe there are numerous and varied reasons why the President placed his faith in my ability to run this important office at the Department of Homeland Security.

My broad and extensive professional experience overlaps with the core areas of responsibility of the Office of Health Affairs. This experience includes expertise in Emergency Medicine, disaster medicine and public health; proven ability to lead organizations, proficiency in operating effectively in challenging environments, and skilled in the scientific process. While I am both honored and humbled by the President's nomination, I am confident that these experiences have fully prepared me to serve the nation well at DHS.

My clinical experiences over nearly two decades have been on the front lines of medicine, caring for the most severely ill and injured. My professional development began in emergency medicine, having worked as an EMT, Paramedic and flight medic all before graduating from medical school. These experiences give me invaluable insight into the challenges, capacities and limitations faced by our local providers every day.

As a physician, I have practiced primarily at tertiary academic emergency departments and Level I trauma centers across the country. The world of emergency medicine is a microcosm of disaster management. A skilled paramedic or emergency physician encounters unexpected problems on a daily basis, often with little to no warning. We must be able to quickly synthesize vast quantities of disparate data, prioritize problems, develop a cohesive treatment plan, convey that plan to the team and execute time critical decisions if the best possible outcome for the patient is to occur.

As a clinical educator, I understand the importance of the clear and comprehensive transfer of information and knowledge to people that will in turn deliver care to others. I have taught hundreds of young physicians, medical students, nurses and first responders about the scientific and clinical aspects, as well as the values of compassion and efficiency in the delivery of medical care. I was recognized for this work and selected as the outstanding clinical teacher by the residents in emergency medicine at Georgetown University Hospital and Washington Hospital Center in May 2009, and as the outstanding EMS physician for the state of Missouri in 2006.

In addition to my expertise as a physician and educator, I have also demonstrated skills in academia and the scientific process. The goal of academic medicine is to reduce disease burden through rigorous scientific evaluation, which parallels the goals of the Office of Health Affairs. I have published on a wide spectrum of issues encompassing the delivery of care in emergency and disaster situations. This includes my research that led to a near two-fold increase in survival of sudden cardiac arrest. For this project, I conducted the background investigation, rigorously reviewed the scientific literature, sought advice from experts, developed the program, taught the program to our out of hospital providers, collected and analyzed the data, wrote the manuscript conveying our results to the scientific community and discussed the findings and issues with the media to deliver a cohesive message on what our findings meant to the population and what our recommendations were for furthering the best in emergency care. I have delivered scientific presentations of my work both nationally and internationally for varying audiences, including emergency medicine, disease surveillance specialists, and public health practitioners.

Being a medical director of high performance emergency medical services systems working within the framework of public health, I have a realistic understanding of the capabilities and inner workings of our emergency response systems. I understand what it takes to get them functioning and able to respond in a crisis and how to effectively run a "system" whose main tenets are efficiency and quality.

Perhaps the most powerful of my experiences was the year I spent in Iraq as a public health team chief on a US Army Special Operations Civil Affairs team, working to rebuild the medical infrastructure, care delivery process, strengthen the medical education system – all while overseeing the well-being of my team. For my efforts, I was honored with the bronze star. This experience has given me incalculable knowledge of operating in a high-tempo, hazardous environment where decisions that are made can have fatal consequences. I applied the same lessons learned from leading a large EMS agency to the battlefield – which is to lead from the front, develop your battle plan using all available intelligence, convey your intent to your team, and allow them to develop the most effective way to execute your intent. Beyond these skills, I also learned the importance of taking care of your troops (especially when confronted with a hostile environment on a daily basis), the value of listening to everyone before making decisions, getting buy-in from the many different actors to bring about a successful completion of the mission, and staying mission-focused.

I have a unique skill set and a wide array of experiences which I believe the President and his team saw that combined made me ideal for the position of Assistant Secretary for Health Affairs and Chief Medical Officer at the Department of Homeland Security. I am honored by his faith in my ability to effectively lead this office and would like to put my knowledge and experience to use in continued service to my country.

2. Were any conditions, express or implied, attached to your nomination? If so, please explain.

No.

3. The "Post-Katrina Emergency Management Reform Act of 2006" (P.L. 109-295) (Post-Katrina Act) created the office of CMO and required the individual appointed to be CMO to possess a demonstrated ability in, and knowledge of, medicine and public health. What specific background and experience affirmatively qualifies you to be CMO?

There are several examples I believe illustrate my ability and knowledge of medicine and public health which decisively qualify me to be the Assistant Secretary and Chief Medical Officer positions.

I have been working in Emergency Medicine through multiple different capacities for close to two decades. My professional career includes residency training and board certification in Emergency Medicine including being selected as Chief Resident as well as Resident of the Year my senior year. Since graduating from residency I continued my career in academic emergency medicine at tertiary referral centers and Level I trauma centers. I have held academic appointments and numerous institutions of higher learning including the University of Missouri, the University of New Mexico and Georgetown University Schools of Medicine. As part of my duties in academic emergency medicine, I have been an instructor for Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), and Prehospital Trauma Life Support (PHTLS). I have delivered lectures in various aspects of emergency and disaster medicine as well as public health.

Besides clinical medicine I developed and taught courses in evidenced-based medicine and the statistical-based medicine. I have instructed hundreds of physicians, medical students, nurses and first responders in emergency medicine as well as actively taken care of thousands of critically-injured and ill patients.

In addition to my clinical and education accomplishments, I have an extensive academic career as well. I have published and presented numerous research projects nationally and internationally at Emergency Medicine, disease surveillance and public health conferences. Furthermore as an Emergency Physician working in high census emergency departments I interact with every medical specialty on a daily basis from internal medicine to the sub-surgical specialties. I have led and participated in trauma team resuscitations my entire career.

Additionally, I began my career in emergency medicine as a paramedic for a high volume, high performance EMS systems in Kansas City, Missouri. I continued this experience by becoming the Associate followed by the Medical Director for the same EMS service. Because of this experience I not only learned the clinical knowledge and skills of delivering care in the streets, but also came to understand the inner workings of a highly developed system of first responders. These included actively working scenes of disasters as a paramedic, triage officer, logistics and as the medical control officer. This "training" has given me an education in the capacity, limitations and abilities of our first responders at the local level to respond to disasters which cannot be taught in any

classroom. I have experience in working in the emergency operations center at the local level and can appreciate their challenges and concerns.

My ability and knowledge in public health is demonstrated began with the awarding of my Masters Degree in Public Health (MPH) from the St. Louis University School of Public Health. I began putting my training in public health to use while working as a medical director within the Kansas City Missouri Health Department. During this time I used the three pillars of public health, assessment, policy development and assurance, to focus my efforts on improving the delivery of health to the community. Using these pillars my office completely re-wrote our operating procedures and protocols for the paramedic and EMTs use. We developed metrics for which the EMS service would be measured and developed policy for the further improvement of care. We tracked various components of patient care using statistical process control procedures. Our efforts paid dividends when our dispatch center was certified as a "Center of Excellence" by the National Academies of Emergency Dispatch (NAED) and the ambulance service as a whole receiving accreditation by the Commission for the Accreditation of Ambulance Services (CAAS). Our EMS service is only one of a handful of services in the country that has attained simultaneously both of these accreditations. I was also instrumental in pushing for the improvement of clinical care in the streets by developing a new resuscitation protocol which increased the survival of cardiac arrest patients by nearly two fold giving our service one of the highest cardiac arrest save rates in the country. We further served the population by developing a translation tool to help our first responders acquire medical information from non-English speakers during the critical first few minutes of care. I expanded my research career to include public health aspects as related to emergency and disaster medicine. I have presented research on using actual events to simulate chemical attacks using real time pre-hospital 911 data and using 911 data to adjust surveillance methods according to conditions on the ground during a disaster.

In addition to my civilian accomplishments in public health, I spent the past 10 years as a public health officer and team chief at battalion and command levels for the U.S. Special Operations Command. While serving as the public health team chief for the 418th Civil Affairs Battalion, I deployed to Iraq in 2003. My responsibilities varied and included being the battalion surgeon. As battalion surgeon, I provided care to our own soldiers in addition to my duties to the team. During this time I was charged with getting healthcare functioning again within our area of operations. Using the principles I learned from my civilian practice and training in public health, my small team was able to accomplish numerous successful projects and missions. From the local clinics to the directors of health for the province, I interfaced with the Iraqi healthcare at all levels. I assisted every aspect of medical care including hospital engineers, pharmaceutical supplies, the public health department, nursing and medical schools, local clinics, private clinics, military medical care, mortuary affairs, and supply delivery. I also interacted with numerous different organizations as well including Non-Governmental Organizations (NGOs), and the Coalition Provisional Authority (CPA). I worked closely with the 4th Division Surgeon's Cell and provided information that was directly briefed to MG Raymond Odierno while he was commanding the 4th ID. This experience gave me unique appreciation for the challenges of global health and an education in negotiating different factions both with the indigenous population and within the US Government.

I believe that my accomplishments, knowledge and experience show that I possess the requisite skills in medicine and public health to execute the duties of this office.

4. Have you made any commitments with respect to the policies and principles you will attempt to implement as CMO? If so, what are they, and to whom were the commitments made?

No.

5. If confirmed, are there any issues from which you may have to recuse or disqualify yourself because of a conflict of interest or the appearance of a conflict of interest? If so, please explain what procedures and/or criteria you will use to carry out such a recusal or disqualification.

In connection with the nomination process, I have consulted with the Office of Government Ethics and the Department of Homeland Security's Designated Agency Ethics Official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with the Department and that has been provided to this Committee. I am not aware of any other potential conflicts of interest.

My recusal will follow the guidelines of the Director, U.S. Office of Government Ethics, especially, the Director's memo for DAEs, DO-04-012, of June 1, 2004, and the advice of the Department's Designated Agency Ethics Official.

6. Have you ever been asked by an employer to leave a job or otherwise left a job on a non-voluntary basis? If so, please explain.

No.

II. Role and Responsibilities of the CMO

7. Why do you wish to serve as CMO?

The Assistant Secretary and Chief Medical Officer position offers challenges for which I believe I am uniquely qualified. From my work as a first responder to my positions at the municipal and state health departments, my entire career has been devoted to public service. My commitment to service is further shown by my year long deployment to Iraq and my continued service in the US Army Reserves. I believe these experiences will allow me to move this office forward by improving overall health security as well as supporting the Department's mission of protecting the American people.

8. What is your view of the role of the CMO?

I see the role of CMO in several different lights. The Chief Medical Officer's primary role within the Department of Homeland Security is to be the principal advisor to Secretary Napolitano and to the FEMA Administrator.

Within the Office of Health Affairs I view the role of the CMO as the leader of a multi-disciplined office. This encompasses all of the challenges that come with being a manager, including clarifying the mission, challenging, informing and motivating the team, establishing the culture of the office and ensuring the office is fulfilling its duties.

Outside of the Office of Health Affairs I view the role of the CMO as the visible head of health affairs for the Department of Homeland Security. This includes delivering products to multiple different customers including the Congress, other departments, other entities within Homeland Security, the media, and the American public.

9. What do you see as the principal mission(s) of the Office of Health Affairs (OHA)?

From my understanding the principal mission of the Office of Health Affairs is clear and directly supports the Department's responsibilities outlined by Secretary Napolitano. OHA supports the Department's mission to enhance protection and create resilience among the American people against terrorist threats, specifically the potential medical and public health impacts of threats. Through OHA's programs such as BioWatch and the National Biosurveillance Integration Center (NBIC), the nation has early detection and early notification of biological threats and attacks. OHA also assists with DHS' mission to secure the nation's borders and enforce immigration laws by supporting the workforce tasked to fulfill that mission. OHA's Office of Component Services supports and promotes the health and safety of every DHS employee. Finally, by working with other Departments and agencies, states and territories, and other stakeholders, OHA is focused on preparing the country for disasters, specifically those with medical and health impacts such as Anthrax attacks and Influenza Pandemic.

10. What do you see as OHA's principal strengths and weaknesses in its ability to accomplish those mission(s)?

Since my nomination, I have had the opportunity to meet with many of the talented men and women of the Office of Health Affairs. I am convinced OHA's doctors, scientists, public health service officers, managers, and other employees are one of the clearest strengths of the office.

Another of the strengths is the relative newness of the office. Within the framework of federal government OHA is still in its infancy; however because of this the office is not

beholden to the view of "that's the way things have always been done", we are not hampered by institutional footing or dogma. The office was developed from a clean sheet of paper which allows our talented personnel the opportunity to think outside the box and view issues from a different angle. This greatest strength is also OHA's greatest challenge. Our office is still young and continues to learn and develop. Regardless, because of the understood urgency involved in OHA's mission the office must continue to understand, adapt and overcome the complexities involved in the execution of duties.

As a young office in a maturing Department, OHA has its challenges; however I am confident that, if confirmed, I will lead the office to continued growth and positive outcomes, with ongoing support from the White House, the Secretary and Congress. As I learn more about areas in need of improvement in OHA, I would welcome further discussion with the Committee to gain input and work toward enhancements

11. The Post-Katrina Act reorganized aspects of DHS to enable the Department to more effectively fulfill its emergency management mission. Since the enactment of this Act, OHA has expanded greatly in both its responsibilities for the programs that it oversees and in its personnel and budget resources.
 - a. Of the duties given to the CMO in the Act, which do you believe have been fully implemented? Which responsibilities have yet to be completely implemented and what actions will you take, if confirmed, to fulfill these duties?

Over the past couple of weeks I have had the privilege of meeting the many talented personnel that make up the OHA and I have been briefed on the programs that they manage. I have only been able to conduct very preliminary evaluations of the various programs that make up the OHA. However, specific to the duties given the CMO I do feel that there have been some successes. These include performing as the principal advisor to the Secretary and FEMA. From what I have come to understand during my briefings, I have the impression that the OHA has made significant inroads in ensuring internal and external coordination of medical preparedness and response activities of the Department including training and exercises. It is also my understanding that the OHA has made progress in becoming the primary point of contact with DHS' interagency partners, particularly Health and Human Services. While these briefings have given me a broad overview of activities, I feel it would be premature to declare which of the programs, are "fully implemented". If confirmed, one of my first actions will be to fully evaluate the different components that constitute the OHA and develop plans and measureable deliverables for full implementation if I find that they are not.

- b. In your view, what role does the CMO have in emergency situations under the Act?

The roles of the CMO in emergency situations under the act are to be the principal advisor to the Secretary and Administrator of FEMA.

- c. In your view, what resources does OHA need to carry out its responsibilities under the Post-Katrina Act?

As I stated earlier, I do not think I would do justice to say which programs are implemented, nor would I be able to speak intelligently about OHA's needs. If confirmed, I will evaluate the components within the OHA and would be able to get a better picture of our needs as well as challenges. If I do find the need for greater resources, I will be sure to communicate this with the Committee.

12. In your view, what are the major internal and external challenges facing OHA? If confirmed, what would you do, specifically, to address these challenges?

As I discussed in Q10, the Office of Health Affairs is a young and growing organization within DHS. OHA has a unique role to play as the voice for the medical and public health aspects of DHS' work to prepare, respond, and recover from disasters or similar events. With the growth of the office comes "growing pains" which are to be expected. While I am sure that there are significant internal and external challenges facing OHA, it would be difficult for me to pass judgment on which are the major challenges of this organization at this early stage. If confirmed, I will only be the second Assistant Secretary of OHA. I look forward to further organizing and solidifying OHA's vision, mission, roles and responsibilities. I share Secretary Napolitano's vision of "One DHS" and if confirmed, plan to address OHA's challenges by working closely with the Secretary as well as the Congress and our external partners. I would certainly welcome Congressional input in identifying challenges facing OHA, and any potential solutions you might offer. If confirmed, I plan to look for opportunities to streamline OHA programs and offices to ensure efficient and effective use of tax-payer resources and to ensure transparency to stakeholders and the public.

I understand the Department is undergoing the Quadrennial Homeland Security Review and if confirmed, look forward to fully participating and executing the strategic vision laid out for the Department and OHA specifically.

13. If confirmed, what would be your top priorities?

One of my first priorities will be to completely evaluate all of OHA's programs. I will accomplish this using various tools including taking a public health and systems approach. We must review our programs to see if we are capable of doing the job correctly (capability), are we doing it correctly (control), have we done the job correctly (assurance) and can we do better (improvement). I will complete this review within the public health paradigm of assessment, policy development and assurance. Based on this careful evaluation, I intend to develop plans for improvement and assurance.

Realistically, if confirmed, I would expect to be operationally focused on preparing for H1N1 again this fall. I am certain that this is of critical importance to the Secretary, OHA, and the nation.

14. The OHA has four primary offices: Weapons of Mass Destruction (WMD) and Biodefense; Medical Readiness; Component Services and Workforce Health Protection Office; and International Affairs and Global Health Security. Please describe your goals in each of these areas. What do you hope to have accomplished at the end of your tenure if confirmed?

Since my nomination, I have spent the last two weeks meeting with the personnel of the OHA's respective offices. During this time I have come to a cursory understanding of the offices and their missions. It would be difficult for me at this time to articulate any in-depth goals for each of these offices. However, overall my goal across the OHA, which includes these offices, is to strive for excellence in their mission's execution, to maintain mission focus and to satisfy its customers inside and outside of DHS. If confirmed, I plan to critically evaluate all of the offices within the OHA, streamline operations where possible, make these offices efficient and effective and establish goals and metrics to measure the progress of these respective offices.

III. Policy Questions

15. What is your approach to managing staff, and how has it developed in your previous management experiences?

I believe creating an atmosphere of excellence, delivering and communicating a clear vision, measuring and rewarding success, and then empowering staff are the best approaches to managing staff.

As medical director for Emergency Medical Services at the Kansas City Missouri Health Department, I wanted our service to be the best in the country. I was fortunate to have a staff who shared this vision and worked diligently towards this goal. My goals for the OHA are the same. If confirmed, I want our component offices to be the best.

Additionally, we must stay mission focused. All of planning, efforts and actions must support the mission. As an emergency physician at MedStar Health our mission was "patient first" which meant that all of our actions should be directed towards the care of the patient. A similar mantra must be adopted in order to be successful at OHA.

I must convey my vision of the OHA and then create an environment so staff can execute appropriately. Managing a staff requires a commitment to establishing a foundation within the organization of excellence. We must realize that like in business models, the definition of success is if the customer is satisfied.

While a medical director I instilled in my staff that we must know our customers and stakeholders and constantly seek to satisfy their needs. This included simple things like promptly returning phone calls or emails to more involved issues such as resolving problems quickly. I met the health director's needs by responding quickly to his need for information when needed, giving him detailed information about the workings of the office so that he would never be blindsided by an issue and meeting regularly to make sure there were never any issues that were lingering. We established an electronic method of tracking service complaints to make sure addressing them in a timely fashion. As a team chief for a Civil Affairs team I personally made sure that the Surgeon's team was satisfied with briefing materials for the Commanding General as well as my battalion command. Fostering this attitude in our staff is paramount to success in the office.

I recognize employees are the most valuable asset. They must be properly challenged, informed and empowered. The personnel in the office are critical to achieving our shared goals. My attitude is to generally give my vision and intent and then allow the staff to develop and execute the plan. As medical director of a large EMS service, our team frequently discovered providers that did not maintain the appropriate licensure requirements or other certifications to maintain licensure. This was due to a labor intensive and poorly designed system of manual audits of paper based files. I discussed this with my staff and gave them my vision of electronic tracking, automatic queries and electronic capture of documents. I assigned the project to one of my assistants and gave

him a deadline. He had the power to develop what he needed to convert the vision into usable product which he did in setting up a database that would generate monthly reports on licensure and certification so that we could act quickly to resolve any issues regarding licensure before they became a problem. This resulted in decreased lost field time by pulling providers off the street, decreased frustration in the office and reassuring the provider we were up to date on critical information.

I used this approach similarly in the military while mission planning. I discussed my strategic mission with my team sergeant (NCOIC) and told him to come up with the tactical plan which he would execute. My team NCO would develop our routes, force protection, vehicle alignment and would assure that our vehicles radios and team were ready to go so that we could execute a successful mission.

I also believe in measuring progress using benchmarks and metrics. As a medical director of a high performance EMS service we set high standards for our providers and for the system. Using statistical process control elements we tracked specific clinical and functional parameters such as response time compliance, skill proficiency, critical charging for high risk conditions, and patient outcomes. We understood that as a system there will be variance but as long as this was random and not systematic that we were in control. As a Civil Affairs officer we tracked our projects using similar metrics although somewhat more rudimentary and arbitrary given the environment.

By creating an atmosphere of excellence, building the foundation, delivering a clear vision and then empowering the people who actually do the work to execute, and measuring success, I feel that we can create a vibrant and productive OHA.

16. How will OHA support DHS's major mission and management areas, including Emergency Preparedness and Response, Critical Infrastructure and Key Resources Protection?

If confirmed, I would make an effort to streamline the Office of Health Affairs (OHA) activities while maintaining the delivery of consistent subject matter expertise across the Department for any preparedness, response, and recovery activities and operations. This would include supporting the Department and partner components in Critical Infrastructure and Key Resource (CIKR) protection activities.

OHA has a cadre of dedicated medical and public health professionals who provide subject matter expertise to the Department's policies, programs, protocols and guidance. The expertise OHA brings to the table is likewise beneficial to a wide variety of DHS stakeholders, such as CIKR businesses and organizations, other private sector partners, the first responder community, and to internal partners such as the FEMA Administrator to ensure the health and safety of people affected by disasters.

I recognize that OHA's success greatly hinges upon its ability to collaborate and build and maintain its partnerships. In order to support DHS' mission, OHA must work closely and collaboratively within DHS and with state, local, tribal and territorial communities, and its Federal interagency partners. Throughout my career, I have been successful in leading organizations with a focus on satisfying the "customers" with various product or services. I would offer the same philosophy to OHA as the offices works to ensure the end-users of advice and guidance are satisfied.

17. Do you see the need for the establishment of a single unified set of Occupational Safety and Health regulations across the entire DHS workforce? If so, should OHA lead the intra-departmental effort? What major challenges do you believe OHA faces in effecting these changes?

It is my understanding that the Designated Agency Safety and Health Official (DASHO), who is the DHS Chief Administrative Officer (OCAO), which is within the Undersecretary for Management Directorate, would be responsible for making this recommendation. If confirmed, I look forward to being a part of discussions about how DHS can best set policy that protects its employees' safety and health and to working collaboratively with the Management Directorate on this issue.

18. The CMO is responsible for programs to ensure the health and safety of DHS employees during their response to emergencies and disasters. While the CMO's responsibility does not explicitly extend to other federal workers, or to other responders in general, the CMO nonetheless was given the responsibility in the Post-Katrina Act to serve as the principal advisor for medical and public health matters to the DHS Secretary and the Administrator of the Federal Emergency Management Agency (FEMA), and as DHS's primary point of contact for State, local, and tribal governments for medical and public health matters.

- a. What role does the CMO play in federally declared emergencies?

The CMO's statutory role as principal adviser to the Secretary and the FEMA Administrator on medical and public health matters is never more important than in a federally-declared emergency. OHA staff sit at the DHS National Operations Center and the FEMA National Response Coordination Center during emergencies, providing subject matter expertise and serving as a liaison to the Emergency Support Function (ESF)-8 desk at the Department of Health and Human Services. In addition, it is my understanding that OHA has also sent representatives to the HHS Secretary's Operations Center for an extra level of coordination. In terms of coordination with FEMA, during hurricane season last year, OHA staff deployed with FEMA Incident Management Response Teams to provide them with medical support.

CMO also provides critical insight into when a medical or public health event is not an emergency to avoid needless overreaction by the emergency operations centers.

DHS must strike a careful balance between maintaining situational awareness to avoid surprise, while not unduly escalating disease incidents or events that are effectively covered by the existing medical and public health infrastructure. CMO calibrates the appropriate level of response on behalf of DHS.

- b. What role will OHA have, if any, in developing and issuing protective action guidance for worker protections against WMD threats?

OHA works closely with the DHS Management Directorate and the Chief Administrative Officer and the Office of Safety and Environmental Programs (OSEP) who serves as the Designated Agency Safety and Health Officer (DASHO). The OHA Office of Component Services (OCS) works very closely with OSEP on many fronts. OCS and OSEP partner to serve as an interface with other Federal Agencies, such as CDC and HHS, advise agency leadership on the medical aspects of workforce protection, and provide input and expertise into the procurement of Personal Protective Equipment (PPE). The CAO who also serves as DASHO is responsible for releasing respirator and other PPE guidance. The Chief Medical Officer, or designated ACMO, writes and provides guidance on medical actions, such as vaccine administration or the dosing and distribution of antiviral medication.

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- c. What responsibilities do you believe DHS as the lead Federal agency for catastrophic incidents, has, for the health protection of non-DHS Federal workers? What do you see as OHA's role in fulfilling those responsibilities?

It is my understanding that OHA works closely with other federal agencies to help ensure that the guidance provided across the federal government is consistent, timely and accurate. It is my understanding that OHA has worked closely with CDC NIOSH, and also with the FACOSH emerging threats subcommittee (Federal Advisory Council on occupational safety and health), as well as OSHA in the Department of Labor. As stated throughout this questionnaire, collaboration with the interagency is critical to achieving success. As an agency with a large amount of operational workforce, we must ensure not only DHS is prepared for catastrophic events, but that we also serve as a model for preparedness and assist our interagency partners.

- d. In catastrophic incidents, which typically involve response personnel from multiple jurisdictional levels, what assistance from Federal agencies is available for ensuring the safety and health of non-federal responders?

HHS is the principal Federal agency for medical assistance in catastrophic events. DHS and the OHA do not provide direct medical care or assistance. OHA offers advice, guidance analysis and subject matter expertise to the Secretary and support our DHS Component services. OHA's response, specific for non-federal first responders would include threat analysis and SME. I look forward to learning more from the experts of OHA, FEMA, and others in DHS to better understand the resources available to ensure the safety and health of non-federal responders.

19. In preparing for and responding to disasters, it is essential that OHA effectively coordinate with other agencies, such as the Departments of Health and Human Services (HHS) and Defense, and that it clearly define its own roles and responsibilities.

- a. How will you and your office ensure the development and maintenance of effective partnerships and coordinate with other Federal agencies?

Immediately, if confirmed, my top priority will be to foster existing relationships and build additional interagency partnerships, with a special focus on the Office of Health Affairs partnership with the Department of Health and Human Services (HHS). There is significant history between OHA and entities within HHS. Again, if confirmed, I would like to continue the weekly calls with OHA's counterparts at HHS and maintain open communication and strive for positive interactions. There are multiple other formal avenues to build and coordinate between Federal agencies, such as:

- The White House Interagency Policy Councils. I am told these groups are a mechanism for working collaboratively with other Departments and agencies on policy issues under the leadership of the National Security Staff.
- Workgroups. There are various workgroups on specific issues such as vaccine prioritization, countermeasure distribution, etc. These interagency groups foster collaboration and coordination very effectively.
- Boards and Committees. OHA provides representation to other agencies' through advisory councils and committees. These groups help maintain awareness of those agencies' activities and to provide information to those agencies about OHA. Groups include the National Biodefense Science Board and the Board of Scientific Counselors for COTPER (Coordinating Office for Terrorism Preparedness and Response), and the National Disaster Medical System governance board, among others.
- Many of these relationships are already in place and if confirmed, I look forward to continuing to find opportunities to collaborate with others to meet our common missions.

- b. What information sharing strategies will you employ?

It is clear that, while the work of OHA relies heavily on information sharing by various agencies, there is significant collaboration still needed to allow OHA programs to function at their best. As I have stated, my goal for OHA is that it be the best. This status cannot be achieved without assisting with the removal of existing barriers, which may include refinement of existing strategies. If confirmed, I look forward to learning more about existing information sharing strategies employed by OHA and assessing their utility and effectiveness. I look forward to discussing the outcome of my assessment with the committee beyond my confirmation.

20. What role do you believe OHA has in developing strategic, operational, tactical or other plans for catastrophic scenarios, from pre-event planning through recovery for departmental efforts? For national planning efforts? How should OHA interact and coordinate its planning efforts with FEMA?

It is my understanding that the Office of Health Affairs (OHA) has a critical role in informing the development of the Federal family of plans. OHA's subject matter expertise is helpful for the strategic plans, Federal concept plans, and on all issues that relate specifically to health and medical or health security.

Under the Integrated Planning System, the Federal government develops plans under 15 National Planning Scenarios. OHA ensures that health threats, health and medical consequences, and mitigation strategies are incorporated into plans from both DHS and the interagency to address all hazards. OHA works in tandem with HHS on these issues as well.

In addition to ensuring that homeland security health and medical key issues are informing Federal plans, OHA has an instrumental role providing medical subject matter expertise into all DHS departmental operational plans. I am told that this role was most recently demonstrated when OHA planners reframed the DHS Implementation Plan for H1N1 to reflect the critical actions required to mitigate the consequences of this imminent threat.

Finally, OHA planners provide critical information that supports State, local, Tribal, and Territorial planning. OHA collaborates with FEMA's Preparedness Directorate to publish Comprehensive Preparedness Guides (CPGs), especially for those that target threats having a significant medical impact, including biological, chemical, nuclear or major natural disasters.

21. The Metropolitan Medical Response System (MMRS) provides financial assistance to regions across the country to assist in medical preparedness for disasters, and to ensure that medical planning is integrated with that of other emergency response providers in a region. FEMA administers MMRS grants, with input and assistance from OHA.

- a. What experience, if any, have you previously had in working with MMRS or MMRS jurisdictions?

I have worked mostly on the periphery of the MMRS while medical director of emergency medical services in Kansas City Missouri. The grant program was administered through the fire department. Our office gave input regarding the medical equipment and supplies.

- b. What do you think is the most significant weakness in the MMRS program? What do you think is its greatest strength?

Since my nomination I have had the opportunity to discuss the MMRS program with the FEMA. I have a basic understanding of their concerns about this program, however without and more thorough review of the program, it would not be possible for me to clearly advocate any weakness at this time. I do believe that the strengths of the program are to create connectivity with our local partners and to assist them in enhancing their medical capabilities and training. If confirmed I will work closely with the FEMA to assist in reviewing the program and offer advice on the medical aspects of this program.

- c. How would you go about improving the MMRS program? What specific changes, if any, would you recommend be made to the MMRS program?

Again, it would be difficult for me at this time to adequately discuss how to improve this program or offer any specific changes. Obviously any program has room for improvement and I am sure that this one is no different. My goals are to work collaboratively with the FEMA and give sound, scientific based medical expertise and opinion with this program. If confirmed, I look forward to working with the FEMA on this important program, and I would welcome any insight that the Committee would provide.

- d. The President's proposed FY2010 budget included a proposal to convert the MMRS program to a new "Medical Surge Grant Program" and the Department has apparently been considering changing how MMRS grants are allocated among jurisdictions. Do you believe that the way MMRS grants are allocated should be changed? If so, why, and how specifically would you propose allocating these grants?

I have come to understand from my briefings by the FEMA that there has been discussion on how MMRS grants are allocated and whether revisions would best serve the goals of the program. However, my understanding is these are still discussions that require a greater amount of stakeholder agreement. Since the grant administration resides in the FEMA, it would be difficult for me to discuss how grant allocation should be changed, if it all. If confirmed, I plan to work with OHA's SMEs to discuss any changes in allocation and look forward to working with partners at FEMA to assist in how best to spend the tax-payers dollars in this important program.

- e. The President's proposed FY2010 budget also suggested that MMRS (or the renamed Medical Surge Grant Program) "serve as a pilot for the application of version 3.0 of the Target Capabilities List." Do you agree with this proposal? If so, how specifically would you implement this proposal? Do you think that the Target Capabilities List is an effective way of gauging the performance of MMRS jurisdictions?

I am afraid that I have not been adequately briefed on version 3.0 of the Target Capabilities List and that it would not be proper for me to comment on whether this should serve as a pilot for the MMRS grant program. From my recent briefings on the TCL, I have gauged that there are some concerns regarding whether this would be

an effective way of gauging performance, however I would reserve any opinion on this important program until I am able to investigate it more thoroughly. If confirmed, I would work collaboratively with the FEMA to discuss this proposal and assist in developing an effective way of gauging performance with input from OHA's partners at the State, local and tribal areas.

22. What role should OHA play in assisting states in training and exercising emergency response providers and clinicians, who may be among the first to see victims of an attack, to respond to a Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) incident?

My understanding is that, The OHA addresses training and exercising for CBRNE events with its community partners through several different mechanisms. The Office of Medical Readiness is tasked with developing education and training for its partners in the community specifically through the office of Training and Education. This office provides health and medical SME to inter and intra agency partners, it recommends and reviews health and medical training and education opportunities to meet the need of first responder customers and serves as training and education SME on the interagency curriculum development in accordance with HSPD-21. The Medical First Responder Coordination Division (MFRCD) operates to assist first responder customers as well by identifying gaps in disaster planning and education. This office conducts first responder working groups on catastrophic event planning and preparedness ideas for best practices such as Anthrax engagement. This is accomplished through the office of Mitigation and Capability Enhancement Branch (mACE) and the Medical First Responder Coordination Division (MFRCD). If confirmed I will continue to reach out to OHA's customers at the state, local and tribal areas to find ways to further provide assistance in training and exercising as well as establish metrics and assurance vehicles within the office.

23. You have extensive experience in surge medical frameworks that will be important in mass casualty events, both during your military service and at the ER One project at Washington Hospital Center. What steps can the federal government and OHA, in particular, take to assist state, local and tribal communities in developing adequate medical surge capabilities to respond effectively to disasters?

HHS is the lead on delivering medical care and assistance during times of disaster; however, there are several examples of how the OHA has assisted the state, local and tribal communities in their ability to develop adequate medical surge capabilities. The most direct example of this is the MMRS grant program. While the OHA does not administer this program, it does serve as the medical SME to the Administrator of FEMA for this program. OHA does not directly fund medical surge capabilities. However, OHA does have significant relationships with state, local and tribal communities which indirectly assist them with medical surge capabilities. These programs underneath the office of Medical Readiness are essential for successful interaction between DHS and its local partners. Within the Mitigation and Capability Enhancement Branch (mACE), OHA personnel assist with grants coordination, risk assessments including vulnerability and consequence assessments within the health and public health sector as well as developing metrics for comparative analysis of the programs. Surge capacities are further enhanced by OHA's education and training efforts. Within this context, the OHA recommends and reviews health and medical training for first responders and serve as SME on interagency curriculum development in accordance with HSPD-21. OHA's outreach to state, local and tribal communities are also augmented within the Medical First Responder Branch that works to identify gaps in first responder disaster planning, resources, grant funding and education. This office works to facilitate the integration of EMS into federal, state, local, tribal and territorial disaster preparedness in partnership with the NHTSA and HHS. If confirmed I plan to continue with review its existing programs to make sure we are meeting customers' needs in an efficient, cost effective and timely manner. If confirmed, I plan to make sure OHA has metrics to measure successes as well as identify gaps and needs.

24. The Department of Defense has developed assets specifically for assisting in domestic mass casualty incidents such as the CBRNE Consequence Management Response Force (CCMRF) to deploy field hospitals and medical personnel or providing airlift capability for patient evacuation for the National Disaster Medical Service. Further integration and coordination of military resources with the civilian medical and public health response would likely yield additional productive partnerships in areas such as providing expanded medical facility capacity or logistics support.
- a. As the former Director of Military Programs at the ER One Institute how do you believe the nation can make better use of its military medical assets and capabilities in responding to national disasters?

My role as Director of Military Programs at the ER One institute took many different routes all of which provide valuable lessons learned for national collaboration with military medical assets. I helped launch and form this office on arriving at the Washington Hospital Center. In the beginning of the program we were focused on creating a cooperative research and development agreement (CRADA) with Navy medicine to collaborate on various different research components including bio-surveillance and treatment for traumatic brain injury. This project was then shifted to focus on bio-surveillance in the emergency department using air samplers and creating a center for the integration of medical assets between the civilian and military sectors. These projects were eventually abandoned with the creation of the Joint Task Force –Capital Medical Region -Medical (JTF-CAPMED) which was a tri-service agency headed by RADM Matcuzen. From here we collaborated on educational product for military and civilian personnel. We have a well established patient simulation center at the WHC which was of benefit for training military personnel, including physicians, nurses and combat medics.

In addition another component within ER One was devoted to electronic learning giving the military the ability to provide training for their personnel remotely, track competency, and develop just in time training for critical functions such as new equipment or procedures. In addition we were in the process of developing an MOU with US Army Special Forces Command (USASOC) Surgeons Office to train Special Forces medics at our facility at the Washington Hospital Center and MedStar Trauma Unit.

My experiences as Director of ER One have given me valuable contacts within the military medical establishment with whom the OHA should be interacting (or currently) with on various issues. Because of this baseline trust, it will make it much easier for the office to interact with these contacts. If confirmed I plan to continue to leverage this relationship to look at how OHA may be able to better utilize military assets and capabilities, especially during times of national disasters.

- b. How can OHA and DHS strengthen the partnership between military and civilian medical communities?

I believe that OHA and DHS can strengthen the partnership between military and civilian medical communities by doing exactly the things that we set out to do at the WHC. We must learn who the actors are at each institution, look at similarities in mission and develop relationships to maximize common goals, such as training, education and disaster planning. If confirmed I look forward to helping establish these relationships.

H1N1 Influenza Pandemic

25. At a recent H1N1 influenza summit Secretary Napolitano described DHS's responsibilities in preparing for and responding to a possible emergence of a serious outbreak of H1N1 in the fall, including coordinating the overall response and engaging the private sector.

- a. How will you and your office support the Secretary in her duties?

In the time that I have spent with OHA staff, it is clear that the team is actively working with partners within DHS and the Federal interagency on actions that are important to H1N1 influenza response. The efforts range from developing guidance documents to providing surveillance information to the Secretary to ensure situational awareness. As an example, OHA is working with the Private Sector Office to develop guidance to the private sector community on what actions they should be considering as they prepare for a potential fall H1N1 flu wave. OHA is also working with the CDC, HHS and the Department of Veterans Affairs to provide guidance to Federal Departments on developing a vaccination plan for employees. Similarly, OHA is working with the CDC and HHS on guidance to States on identifying and validating their prioritized Critical Infrastructure and Key Resource (CI/KR) workers for vaccine. OHA is also working on several issues centered on the protection of the DHS workforce, including vaccine and antiviral acquisition, distribution and prioritization, as well as personal protective equipment and others.

I have been fortunate to work as a paramedic, a military officer, and an emergency physician, dedicated to protecting and improving the health of people. Leading and supporting efforts to prepare for and respond to the H1N1 flu are of high priority to Secretary Napolitano and DHS. If confirmed, I would continue the strong focus that OHA staff have placed on supporting the nation's response to an influenza outbreak, and would continue to accept new ways to support the Secretary and the Federal Government's duties.

- b. What actions, planning, or guidance development does DHS and OHA need to accomplish before the fall influenza season?

Since the early days of the H1N1 influenza outbreak, OHA has been working diligently to develop and finalize guidance in different areas. OHA is working with other components and the DHS management directorate to complete guidance on vaccine distribution, dispensing and use of antiviral medication, and guidance on the use of personal protective equipment. OHA also continues to work with the DHS Private Sector Office and CDC to produce guidance that assists the nation's private sector in their response to the H1N1 flu. At the same time, OHA is working to support FEMA by providing advice on how to handle an evacuation in the face of a significant new flu wave. OHA is working to complete each of these items prior to the fall.

In the course of the recent briefings I have received, it is clear that OHA staff is highly focused on flu preparedness deliverables. This is consistent with direction from Secretary Napolitano, who has charged DHS with acting swiftly to support and lead the protection of the public's health and safety, including that of the DHS workforce. If confirmed, there is no question that the development and implementation of flu preparedness and response strategies will be a high priority as I lead the OHA team forward. In addition, as resources allow, I would look to apply a similar sense of urgency for preparedness and response strategies focused on other threats with health and medical consequences.

- c. How will you work with the critical infrastructure coordinating councils, and the private sector members of these councils, to help address the challenges that will require coordination between the federal and private sectors for a pandemic?

It is my understanding that OHA has a history of being engaged with the sector coordinating councils on challenges relating to pandemic influenza. OHA assisted in the drafting of individual sector specific plans for all 18 of the CI/KR sectors. The sector coordinating councils are a valuable resource for DHS to learn how the Federal Government can best support our critical infrastructure partners, particularly as they prepare for health threats like influenza. If confirmed, I will continue these relationships, and also seek out innovative ways to enhance them.

26. The Government Accountability Office (GAO) has called for greater clarification of roles for responding to a pandemic influenza event, including in recent testimony before this Committee's Subcommittee on State, Local, and Private Sector Preparedness and Integration (GAO-09-760T).

- a. What is your understanding of the respective roles of DHS and of the Department of Health and Human Services in responding to a pandemic?

The Department of Health and Human Services, as the lead agency for ESF 8, leads the medical and public health response to any event, including a pandemic. DHS, under HSPD-5, leads the overall coordination of any event that has the potential to disrupt society.

The current structure provides the opportunity for DHS to focus on the needs and the directions of the Secretary for Homeland Security, and to support and communicate with other DHS components, first responders, emergency managers, CI/KR partners, homeland security advisors, and private sector stakeholders. This model also allows for DHS to support HHS in the health response as requested by HHS, such as OHA's leadership on the vaccination plans for the federal workforce and critical infrastructure and key resource stakeholders.

While OHA is certainly a focal point of DHS leadership, the work of DHS in a pandemic stretches beyond OHA to nearly all other DHS components, especially

those with a responsibility to protect our nation's borders and ports, the Operations and Coordination Division, and the Policy Division. Collaboration among DHS, HHS and other federal agencies is of central importance among all of these components, and the ability for OHA to play a coordinating role is particularly valuable in an incident with health and medical consequences. Even as I prepare for what I hope to be a successful confirmation process, I am working to engage HHS, including CDC, and other interagency leadership to begin building relationships that will be crucial to delivering the most effective national response to incidents that present a risk to the public's health.

- b. What is your understanding of how the Secretary's recently announced H1N1 Regional Coordination Teams (RCTs) will function?

As it was explained to me, the Regional Coordination Teams (RCTs) will report from the field through the Operations and Coordination Division. The RTC model is designed to take advantage of already existing DHS leaders who work in the various regions at a variety of components. The selected individuals are being trained to work together to support DHS in the event of a long-term pandemic influenza. Specifically, these teams will support DHS in the field by providing a regional link to our Federal partners; identifying and responding to critical needs; identifying and helping to reconcile regional conflicts; assisting DHS component and Federal partners to coordinate and collaborate; and coordinating with safety and health officials to protect federal workers.

- c. How will OHA interact and support the RCTs?

I understand that OHA has been involved with the RCT program since its inception, providing subject matter advice. OHA is continuing in its role supporting the RCT program by providing medical and health information, outreach to DHS stakeholders, and by providing information on the pandemic preparedness and response activities at the Federal level to the RCTs.

As an emergency room physician, my daily work often involves coordination among multiple health professionals, law enforcement, and first responders. Similarly, my experience in the military demonstrated the importance of strong and clear lines of communication. If confirmed, I would look forward to continuing OHA's support of the RCTs and be open to new ways to refine and strengthen that support.

- d. What roles will the RCTs and OHA have that are distinct from those of the Centers for Disease Control and Prevention and the Department of Health and Human Services?

There are many critical ways in which OHA has a distinct role from the CDC and HHS. OHA serves as the medical advisor to the Secretary of DHS and the FEMA Administrator, and provides expertise and oversight on medical and public health issues across DHS. This direct accountability to the Secretary and the Administrator as a medical advisor are responsibilities that do not exist for any entity outside of

OHA. The experience of the initial H1N1 outbreak is a good example of why OHA is so critical. While the Secretary certainly could, and on occasion did, reach out directly to HHS, including CDC, it was OHA that she turned to for support of DHS component readiness, for awareness of interagency actions taking place, and for communicating with DHS stakeholders. In addition, OHA represents the Department at medically and scientifically related interagency policy and planning committees, workgroups, and councils to ensure that DHS's equities are well represented. For an agency that is responsible for protecting our nation's borders and ensuring an overall coordinated response to a variety of incidents, this representation of DHS equities in the interagency is vital. In addition, OHA provides advice and information directly to the Secretary as well as to the Components and provides guidance to the Components on DHS workforce protection issues. DHS also has a specific responsibility to support critical infrastructure and key resource stakeholders.

My understanding of the RCTs is that they are intended to support execution of the Secretary's direction in the field and serve as a regional conduit between federal partners engaged in the pandemic response effort, including CDC and HHS. Additionally, the RCT's assist DHS component and other federal interagency leaders in the field to coordinate and collaborate to achieve nationally directed strategic objectives, including those related to entry/exit screening, quarantine, isolation, vaccination, continuity of operations, and continuity of government.

27. During the H1N1 outbreak, DHS issued unclear accounts of its screening protocols at the border. DHS initially characterized its posture as one of "passive screening," and subsequently struggled to overcome its characterization of the process as passive. More importantly, DHS failed to articulate exactly what an "active screening" process would entail and when such a process would be implemented at the border.

- a. What do you understand passive screening to entail?

My understanding is that passive screening is a visual observation of individuals crossing the border where DHS personnel look for obvious signs of an illness. In active screening DHS officials could also ask specific questions to determine if an individual is ill or possibly exposed. If these questions indicate the need for a health examination then HHS personnel or other health professionals could conduct a physical exam, or administer a diagnostic test.

- b. In your opinion, what should be the specific actions and determinations that would need to take place in order to escalate screening at the border? Is this a decision that DHS or HHS should make? How should this determination be handled within DHS? What role should OHA play in making this decision?

Decisions on screening at the border have been based on the best science available, and should continue to be based on this expertise. DHS should continue to look to HHS for guidance on whether the science necessitates additional screening at the

border. If HHS, specifically the CDC, determines that the public's health and safety would be best protected by increased screening at the border, DHS and HHS should work together with our border protection services, the transportation industry, and state, local, and tribal governments to determine how to implement the screening.

- c. What do you believe that an active screening process should entail?

Input from the DHS components, OHA, and HHS would be key to developing this process. Based on my current understanding, active screening could involve making an assessment based on a visual observation of the traveler and a series of questions to determine if the traveler may be ill or has been exposed to a certain illness. Based on the results of that assessment the traveler could be referred to public health personnel for a more detailed public health assessment.

- d. Which agency should be charged with developing the guidelines for such an active screening process?

HHS, specifically the CDC, should be the agency in charge of developing the guidelines for the public health aspect of the screening guidelines. However, it would be important for HHS to work in coordination with DHS, DOJ, DOS, DOT, and many other federal departments because of the potential effects screening might have on a range of security, safety, and economic interests.

- e. Which agency should make the determination about when border screening should be escalated?

It is DHS's responsibility to protect our borders, but the decision to escalate border screening has been and should continue to be made based on the best science available. With this in mind, this decision should be made based on a recommendation from HHS.

28. There has been concern in Congress that DHS has not put forward a cogent explanation for when their frontline staff would be allowed to wear protective masks. DHS has issued conflicting public statements about this, and the guidance that has been given to employees has sometimes appeared to be at odds with some of these public statements.
- a. What do you believe should be the guidance given to DHS personnel concerning the use of protective masks?

The most important asset in DHS is its workforce. Their protection should always be at the forefront of DHS missions. In my briefings with DHS staff and leaders, it is clear that workforce guidance continues to be a priority work area for DHS. Given the many employees from several agencies within DHS are in frequent contact with the public, including travelers, crafting appropriate workforce guidance should continue to be a priority for DHS. I am aware that DHS currently follows CDC guidance on personal protective equipment, and updates the guidance on mask and respirator use as new CDC guidance is available. While OHA plays a key role in finalizing the guidance, CDC recommendations drive the policies adopted. I believe this approach is sound because it ensures that DHS is providing guidance that is based on what science validates as the most effective strategies to protect an individual's health.

If confirmed, I will work with OHA personnel, DHS component leadership, and CDC experts to continue to provide medical advice and input so that DHS provides guidance that will most effectively protect the health of DHS employees

- b. Under what circumstances do you believe that DHS personnel should be allowed to wear masks during the course of their primary responsibilities (i.e. during primary inspections at the Ports of Entry or during TSA screening)?

All DHS personnel should feel comfortable and protected in the workplace. Sometimes that will be accomplished by education, sometimes by workplace environmental adaptations, and sometimes through use of personal protective equipment. While I would need input from staff at partner agencies and components in order to answer the question posed here directly, I agree that the development of policy on mask use is a collaborative effort that begins with CDC guidance. OHA is continuing to work with CDC and others on this topic to provide adaptable but clear guidance to DHS employees.

If confirmed, the protection of the DHS workforce in the face of health and medical emergencies is a mission that I would focus on as one of OHA's most important.

29. The Committee has heard conflicting accounts concerning whether technology has a useful role to play at the Ports of Entry to assist in screening during health emergencies. Several nations use thermal imaging devices as part of a layered screening protocol during such emergencies.

- a. Do you believe that there are existing technologies that could be leveraged to assist in screening during pandemic health emergencies?

I understand that HHS is working on the development of a number of diagnostic tools that could be beneficial in rapidly identifying sick people. While HHS has not determined a need for deployment of screening technology at this stage of the H1N1 influenza outbreak, I am aware that DHS and HHS are both very interested in technologies that could make a difference in mitigating the spread of flu. If confirmed, I will be committed to close communication with HHS, including CDC. As this communication continues, I am very interested in learning the full range of technology and other mitigation strategies that are available.

- b. Do you believe it would be worthwhile for DHS to conduct a pilot program using technology to assist with border screening during health emergencies?

As I noted in the previous question, however, if confirmed, I am interested in learning the full range of possibilities that exist to mitigate the spread of disease in a health emergency, and how OHA can be partner in such strategies.

30. This Committee previously investigated the poor communications and coordination between DHS and the CDC in an incident involving a Mexican national with a multiple-drug-resistant form of tuberculosis who was able to enter the U.S. twenty-one times after being identified by U.S. officials.

- a. What can the Office of Health Affairs do to ensure the timely communication of health threats that develop overseas to DHS and its components in order to formulate an appropriate response?

It is my understanding that DHS and CDC have worked together to address the example cited in this question. However I am interested in any insights or best practices from this Committee or other external experts to ensure DHS and CDC are fully coordinated to ensure this does not occur again in the future.

According to my briefings, OHA, working in collaboration with DHS Operations and Coordination, Customs and Border Patrol (CBP), the Transportation Safety Administration (TSA), and the CDC Division of Global Migration and Quarantine

(DGMQ) developed a traveler restriction protocol and an interagency communication flow procedure to address people known to be coming into this country with infectious diseases who could potentially pose a public health threat. On call 24 hours a day, seven days a week, medical officers within OHA provide approval of CDC requests for information when it becomes known that an airline passenger has a communicable disease and requests for action when the CDC is aware that a person with a communicable disease is not compliant with treatment or intends to travel while contagious. The OHA medical officer on call reviews the information and then will make a determination on whether the traveler should be placed on TSA's Do Not Board list and CBP's Traveler Enforcement Compliance System. The system also built in the safeguard of sharing information about other travelers who may have been at risk due to their proximity, in an enclosed space, to the infected traveler

- b. Following this incident, the GAO recommended that DHS and HHS work together to inform and educate state and local health officials about procedures for responding to incidents of travelers that might be infected with dangerous pathogens. What has DHS done, and what would you do if confirmed as CMO, to ensure that there is appropriate coordination with state and local health officials before and during such incidents?

The OHA medical officer system with the Traveler Restriction Protocol and interagency communication flow procedure was a direct response to the lack of coordination in the case cited here, and the recommendations that subsequently followed the incident. I believe that the protocol has strengthened DHS's working relationship both among DHS components, and with HHS, including the HHS Secretary's Operations Center and the CDC's DGMQ.

While CDC has strong systems set up to communicate efficiently and effectively with state and local health officials, if confirmed, I would be very interested in learning how DHS could contribute to this coordination. For example, DHS may have an opportunity to utilize its relationship with state Homeland Security Advisors to ensure that they are also communicating with their local health officials on a given incident. I understand this incident raised serious concerns for many within the federal interagency as well as outside of it. I would look forward to discussing innovative approaches to further support the safeguards that were developed.

If confirmed as CMO, I will ensure that we periodically evaluate this program and make any necessary adjustments.

BioWatch Program and National Bio-Surveillance Integration Center

31. The BioWatch program provides a bio-aerosol environmental monitoring system to our Nation's largest cities for early detection of biological attacks. Currently deployed systems have proven to be highly sensitive with low false positive alarm rates. However, the BioWatch program has faced criticisms over costs and hesitations of jurisdictions to rely on the results from the system to initiate public health actions.

- a. What in your view is the value of the BioWatch surveillance system?

In my view, the core value of BioWatch is its ability to prevent or reduce catastrophic loss of life when encountering a bioterrorism event. Early detection is critical to initiating response actions including medical intervention because of the short window of opportunity available in an event such as an anthrax attack. In essence, we use this technology to increase the rapidity of the decision cycle. BioWatch attempts to provide this capability. I liken this to my work in cardiac arrest resuscitation. We know that every minute that a cardiac arrest patient goes without resuscitative efforts the likelihood of survival decreases by 10%. Likewise we know that with every lost minute in a bioterrorism event, we will increase morbidity and mortality. Without the early detection capabilities of BioWatch, recognition and confirmation of an attack would not begin until sick individuals seek medical care, and this would depend on an astute clinician recognizing that the patient had been exposed. Syndromic surveillance, though needed and useful, is after the fact surveillance, it is "far right of boom". Active sampling with programs such as Biowatch move our actions leftward on the axis, closer to "boom" so we may potentially decrease the excess morbidity and mortality burden on the population and instigate a mitigation strategy. Despite the challenges that the BioWatch program has experienced, it is a worthwhile endeavor whose mission is sound.

- b. What further steps should be taken to improve confidence in the system and response procedures so that positive results are responded to swiftly in a manner that limits casualties from a biological attack?

I have been informed that OHA is in the process of testing, evaluating, and procuring new technology for BioWatch that will provide enhanced detection capabilities and will significantly reduce detection time.. The strong commitment to thorough testing with this new generation of BioWatch technology is the first step needed to improve confidence in the system. Additionally, OHA BioWatch program staff continue to work with federal, state, local, and private sector partners in formulating guidance and protocols for the jurisdictions in responding to a BioWatch Actionable Result. Additional tools should also be developed to arm the jurisdictions with information to complement BioWatch. I am aware that both OHA and S&T are working on some efforts and tools that will speed incident characterization and offer additional decision support (e.g., Biological Warning and Incident Characterization, as well as a technology to determine viability of an agent). These efforts will put more

information in the hands of decision-makers to complement BioWatch results and further enhance their confidence in initiating response actions.

I recognize that the jurisdictions as well as our federal partners, such as CDC, need to have confidence in the deployed technology both for the jurisdictions to request support in responding and for the federal government to respond. If confirmed, I would continue to listen to feedback from our state, local, and federal partners in order to inform decision-making, and to deliver the most effective BioWatch model as efficiently as possible.

32. OHA is overseeing the development of an automated third generation BioWatch program. Recently, automated systems deployed in New York City experienced technical difficulties and their activities had to be curtailed.

- a. Do you believe OHA has the resources and expertise to fully develop and deploy the next generation BioWatch system?

Over the past few weeks, I have been in contact with staff at the Office of Health Affairs (OHA) to increase my understanding of OHA programs and organizational structure. Based on what I have learned to date, I believe that the existing BioWatch management staff is committed to the BioWatch program and has worked diligently to address the challenges in the program.

If confirmed, I look forward to working with OHA staff to ensure the office has adequate resources to carry out its critical mission. It is important that I completely understand the range of capabilities of the next generation of BioWatch, what it can provide as well as the amount of resources that it requires. If confirmed, I would work closely with OHA staff to ensure the office continues to provide its expertise to leadership, partners, and stakeholders. I would be pleased to discuss this issue in more depth after I have been able to have more detailed discussions with OHA staff.

- b. What is your understanding of the timeframe for fielding automated BioWatch systems?

I am aware that OHA is working deliberately to deliver an automated BioWatch system. Currently, as I understand, OHA is in the process of testing, evaluating, and ultimately procuring next-generation autonomous detection capabilities, called Gen-3, for the BioWatch program. I have been told that OHA plans to conduct field-testing on prototype detectors from March 2010 through June 2010 with a report on functionality completed in September 2010. Based on those results, more testing would take place in the field in August 2011 in a system-wide Operational Test and Evaluation. Testing of these production systems is scheduled to be completed by January 2012. I understand that the deployment and operation of the BioWatch Gen-3 is projected to begin service in April 2012.

It is also my understanding that this timeline, is what will best support the deployment of technology that is fully tested and highly effective. I completely support rigorous, science-based evaluation of our equipment, especially with one of such importance in our biodefense architecture. If confirmed, I would work with OHA staff to ensure that we are doing all that we can to deliver the highest quality of technology in the most efficient way for this important program.

33. The National Biosurveillance Integration Center (NBIC) since its inception has struggled to get effective participation and data from other Federal agencies.

- a. What approach will you follow to get more cooperation and participation from key federal agencies?

If confirmed, I would continue to encourage NBIC's collaborative approach to information gathering and analysis. I understand NBIC has revised its approach in cooperating and working with key federal agency partners and is using formal requests for information to solicit participation from member agencies. I would like to visit with each partner agency as one of my first activities as Assistant Secretary for OHA and Chief Medical Officer to gain an understanding of their opinions on NBIC and to foster a more collaborative relationship. In attempting to build a robust program with 360 degree situational awareness, OHA must have buy in and collaborative relationships with all partners in other agencies. OHA must recognize as well that their partners are also our customers in the products produced by NBIC. In my view, NBIC should produce and disseminate actionable, value-added information to the partner agencies and work daily to demonstrate the program's value.

As I gain further information and assess NBIC's partnerships, I look forward to working with the Committee on effective approaches to gain collaborative relationships and participation of key sister agencies.

- b. Who do you view as minimal key federal partners to ensure a robust biosurveillance sharing capability?

During my brief interactions and briefing's with NBIC leadership, I understand that NBIC's already has a formal NBIS agreement in place with a core group of five federal agency partners, who have vested interests in a robust biosurveillance sharing capability and environment. These partners consist of: The Departments of Health and Human Services (DHHS), Defense (DOD), State (DOS), Interior (DOI), and Agriculture (USDA). More recently, NBIC has formalized a separate agreement with HHS, another NBIS agreement with Commerce (DOC) as well as a separate NBIC agreement with the Department of Veterans Affairs (VA). The level of "participation" may be variable amongst the different agencies which will require deeper evaluation. However, each brings value to the system and I will encourage and look for new ways

to improve information sharing. This is urgently needed with the eminent return of H1N1 to our population this fall.

After I am confirmed, I feel I will have a better idea of what each federal partner brings to the table and more insight into the depth of our relationship with our partners. NBIC should continue to develop and ensure that we have robust capacity and capability.

- c. What would be the benefit, if any, to a more distributed information technology approach that allows contributing entities to retain control over their own data rather than the more centralized architecture currently used in the NBIS 2.0 system? If a new information technology (IT) approach is required, what DHS office(s) should develop it?

In my experience with data sharing environments, the question of "who owns the data" can make or break any sharing environment. I have not been exposed yet to NBIC's current information technology (IT) approach, but I understand NBIC has started initial work to establish and implement a centralized architecture to link IT capabilities. I liken this to my work in the emergency department. In taking care of the patient I must have information from different components of the health care realm. Although pathology "owns" the laboratory, radiology "owns" the radiograph and medical records "owns" the history, however I need all of this information to evaluate the patient, put their complaints into context and formulate a "best" plan. The best companies understand the value of integrating all elements of the system to satisfy the needs and wants of the customer in a timely and effective manner. They eliminate organizational barriers to permit improved communication and provide high-quality products and services. Without the ability to amalgamate data into a single usable platform it would be laborious and inefficient to analyze or develop succinct 360 degree situational awareness that is needed for homeland security. On the issue of development; I do not think right now I have the institutional visibility into which office would be the best to develop the approach.

I look forward to learning more about this system and working with this committee to move a quality concept forward and further improve NBIC's capabilities. From my experience, fragmented and segregated data can often be a barrier to truly robust systems that allow rapid and accurate sharing of data, information analysis, and disease or community surveillance.

- d. The NBIC has an operating budget of \$8 million per year which primarily supports salaries of NBIC personnel, leaving very little for continued development and expansion of technology systems. Do you believe the NBIC receives an appropriate

level of resources? If not, at what level should NBIC be funded to accomplish its primary functions?

I have not been informed of OHA's budgetary issues at this point. If confirmed, I look forward to working with OHA staff to ensure the office has adequate resources to carry out its critical mission in an innovative, efficient, and transparent manner.

- e. Currently, NBIC receives the majority of its actionable data from a Director of National Intelligence funded project at Georgetown University which reviews open source data globally to identify potential public health incidents. Legal restrictions on DNI prohibit this service from collecting and analyzing domestic data. This domestic gap is significant when you consider that H1N1 struck so close to our border and quickly spread within the U.S. Do you believe that we need to develop an open source analysis capability to identify and track public health incidents within our borders? Who do you believe should be responsible for funding such a capability?

As I believe you are aware and as I understand, NBIC is receiving actionable information daily information from ARGUS, the Georgetown University organization to which you are referring. I also understand that there are limits on the information ARGUS provides to the NBIC because of the issues with access to domestic information. So I agree this shortage of domestic information could become an important biosurveillance information gap for an event such as H1N1 or other events. I know that NBIC is aware of this potential gap and have been informed they are attempting to address this gap. I am afraid that I cannot address your concerns specifically, but if confirmed will promptly review and address this important issue.

With this being understood, I want to make clear that I'm very sensitive to gathering and analyzing domestic information, even for biosurveillance efforts. We need to make sure that before ANY domestic information is added into our biosurveillance information suite at DHS, that the rigorous and important requirements to ensure people's privacy is properly protected and there are NO civil liberties/civil rights concerns. I would look to work with the DHS Privacy office as well as the Office of Civil Rights and Civil Liberties on efforts such as this. I know that privacy and civil liberties protections are important to both the Secretary and the Congress as well.

34. What do you see as the respective roles and responsibilities of OHA and the Science and Technology Directorate in developing and fielding new biodefense technologies?

It is my understanding that OHA is an operational entity, whereas S&T is responsible for supporting OHA's operations through development of biodefense technologies for programs such as BioWatch and the National Biosurveillance Integration System (NBIS). In essence, OHA is one of S&T's customers. OHA is responsible for identifying biodefense capability gaps and defining operational requirements for biodefense technologies to further the homeland security mission. OHA provides S&T with the strategic vision for biodefense to enable prioritization of research and development efforts.

If confirmed I look forward to strengthening our association to further pursue the cause of the health aspects in homeland security.

IV. Relations with Congress

35. Do you agree, without reservation, to respond to any reasonable summons to appear and testify before any duly constituted committee of the Congress if you are confirmed?

Yes.

36. Do you agree, without reservation, to reply to any reasonable request for information from any duly constituted committee of the Congress if you are confirmed?

Yes.

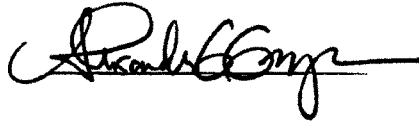
V. Assistance

37. Are these answers your own? Have you consulted with DHS or any interested parties? If so, please indicate which entities.

Replying to this questionnaire with an appropriate level of detail to answer the questions fully and thoughtfully required consultation with certain DHS personnel in regard to matters about which I did not have specific knowledge. Intending to be fully responsive to the Committee in the available time, I have engaged in the normal pre-confirmation discussions with the White House and DHS headquarters staff. These discussions added breadth and depth to my knowledge regarding the background, status, and general plans of the Department such as are relevant to the position to which I have been nominated. However, and in every instance, the answers provided in this response are my own, based on my best understanding and analysis of the information which I have been provided.

AFFIDAVIT

I, Alexander Garza, being duly sworn, hereby state that I have read and signed the foregoing Statement on Pre-hearing Questions and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.



Subscribed and sworn before me this 22nd day of July, 2009.


Notary Public

Lydia Stampley
Notary Public, District of Columbia
My Commission Expires 8/14/2010



United States
Office of Government Ethics
 1201 New York Avenue, NW., Suite 500
 Washington, DC 20005-3917

July 9, 2009

The Honorable Joseph I. Lieberman
 Chairman
 Committee on Homeland Security
 and Governmental Affairs
 United States Senate
 Washington, DC 20510

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Alexander G. Garza, who has been nominated by President Obama for the position of Assistant Secretary and Chief Medical Officer, Department of Homeland Security.

We have reviewed the report and have also obtained advice from the agency concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is an ethics agreement outlining the actions that the nominee will undertake to avoid conflicts of interest. Unless a date for compliance is indicated in the ethics agreement, the nominee must fully comply within three months of confirmation with any action specified in the ethics agreement.

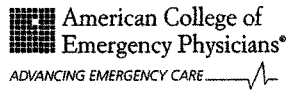
Based thereon, we believe that this nominee is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert I. Cusick".

Robert I. Cusick
 Director

Enclosures : Redacted



July 20, 2009

The Honorable Joseph Lieberman
Chairman
Senate Committee on Homeland Security and
Governmental Affairs
SD-340
Washington, DC 20510

Dear Chairman Lieberman:

On behalf of the American College of Emergency Physicians (ACEP), I would like to express our strong support for the nomination of Alexander G. Garza MD, MPH as Assistant Secretary of Health Affairs and Chief Medical Officer for the Department of Homeland Defense. ACEP is a national medical specialty society with more than 27,000 members dedicated to improving the quality of emergency care through continuing medical education, research and public education.

Dr. Garza is an emergency physician who has a very diverse and accomplished background including directing large EMS agencies, being a leader in public health an accomplished academician and teacher, as well as being a decorated veteran. He has practiced and taught emergency medicine at multiple programs across the country including the University of Missouri, the University of New Mexico and Georgetown University Schools of Medicine.

ACEP is proud of Dr. Garza's service to his patients, his colleagues in emergency medicine and to national service. We fully support his nomination and urge the committee to approve his appointment.

Sincerely,

Nicholas J. Jouriles, MD, FACEP
President

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Public Health
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Protect, Prevent, Live Well

July 23, 2009

The Honorable Joseph Lieberman
Chairman
Senate Committee on Homeland Security and
Governmental Affairs
SD-340
Washington, DC 20510

Dear Chairman Lieberman:

On behalf of the American Public Health Association (APHA), I write to express our strong support for the nomination of Alexander G. Garza MD, MPH as Assistant Secretary of Health Affairs and Chief Medical Officer for the Department of Homeland Security. APHA is the oldest and most diverse organization of public health professionals and advocates in the world dedicated to promoting and protecting the health of the public and our communities.

Dr. Garza is an emergency physician with a diverse and accomplished background including working in public health agencies at the local and state levels as the director of large EMS agencies. He has led public health efforts both nationally and internationally through his work while serving in the US military. Dr. Garza is also an accomplished academician who takes a population approach to his studies and a systems approach to his administrative duties. Furthermore, he is a well regarded clinician and teacher, holding academic appointments at the University of Missouri, the University of New Mexico and Georgetown University School of Medicine.

APHA is proud of Dr. Garza's service to patients and students, his colleagues in public health and to our nation. We fully support his nomination and urge the committee to approve his appointment.

Sincerely,

Georges C. Benjamin, MD, FACP, FACEP (E)
Executive Director

cc: The Honorable Susan Collins

Dalton E. Diamond, MD, MPH, FAAFP
67 Pine Needle Trace
Guntersville, AL 35976

24 July 2009

The Honorable Joseph Lieberman
Chairman
Senate Committee on Homeland Security and Governmental Affairs
SD-340
Washington, DC 20510

Dear Chairman Lieberman:

I am writing this endorsement on behalf of the nomination of an outstanding American patriot and scholar, Doctor Alexander G. Garza, for the office of Assistant Secretary of Health Affairs and Chief Medical Officer for the Department of Homeland Security.

I have known and worked closely with Dr. Garza since 2001. As Deputy Chief of Staff, Deputy Surgeon and then Surgeon for Army Special Operations Command I was the senior medical officer for Alex's U.S. Army Civil Affairs and Psychological Operations Command. I was impressed from the start with his ability to weigh information from disparate sources, ascribe proper value, and synthesize the whole into actionable medical and public health intelligence. Dr. Garza's work in Iraq was most impressive and his understanding of how cultural sensitivities can be integrated into operational imperatives was brilliant. Working across agency, institutional, and international boundaries was his daily fare and he excelled. His success in executing the mission, shoulder to shoulder, with the highest foreign governmental officials, U.S. Theater Commanders and their staff, International and Non-Governmental Organizational entities, and U.S. Interagency personnel was outstanding. In my opinion he possesses a complete and - more importantly - workable framework for the interagency challenges of the position for which he has been nominated.

Dr. Garza also has an impressive resume of academic, administrative, and clinical achievements which lends professional credibility and further makes him the ideal candidate for senior government service. He is intelligent, resourceful, innovative, and, most of all, realistic. The position for which Dr. Garza has been nominated is not an easy job. It requires knowledge, integrity, dedication, stamina, and personality. Alex has it all. I am proud to know him and feel strongly that he is absolutely the right choice for Assistant Secretary of Health Affairs and Chief Medical Officer of the Department of Homeland Security.

Inquiries may be addressed to the undersigned at 256-572-4535 or <dalton.diamond@us.army.mil>


Dalton E. Diamond, MD, MPH, FAAFP
Colonel, Medical Corps, USAR

cc: The Honorable Susan Collins



**JOINT TASK FORCE
NATIONAL CAPITAL REGION MEDICAL**
8901 WISCONSIN AVENUE, BUILDING 27
BETHESDA, MD 20889-5605

27 July 2009

The Honorable Joseph Lieberman
Chairman
Senate Committee on Homeland Security and
Governmental Affairs, SD-340
Washington, DC 20510

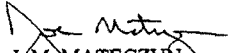
Dear Chairman Lieberman:

I would like to share my personal knowledge related to the nomination of Doctor Alexander G. Garza as Assistant Secretary of Health Affairs and Chief Medical Officer for the Department of Homeland Defense.

Dr. Garza is an emergency physician who has a unique and accomplished background. He has led large EMS agencies at the municipal and state level and has held academic appointments at multiple different schools of medicine across the country. His attributes as a U.S. Army officer are evidenced by his accomplishments as a preventive medicine officer and a team chief for a civil affairs team, including tours in Iraq and in Africa. As such, he is able to understand the complexities of health care, health threats and planning for catastrophic events across the full spectrum.

Dr. Garza has worked closely with my staff at Joint Task Force National Capital Region Medical which was established in September 2007 by the Deputy Secretary of Defense to oversee the delivery of integrated healthcare for our warriors and their families in the NCA, ensure force readiness, and execute the BRAC business plans. We have been engaged with Dr. Garza as the Director of Military Programs at the Washington Hospital Center for over two years. We have met with Dr. Garza and his staff on multiple occasions and have developed a strong working relationship to improve the delivery of healthcare to our Soldiers, Sailors, Airmen and Marines and plans for contingencies in the NCR. He has a strong understanding of the healthcare needs of our nation's warriors and is dedicated to ensuring they receive the best care possible.

Thank you for the opportunity to share my personal knowledge of Dr. Garza's qualifications. Should your staff desire any further information, I am available at (319) 319-8400.


J.M. MATECZUN
Vice Admiral, MC, U.S. Navy
Commander

cc: The Honorable Susan Collins



National Association of EMS Physicians
P.O. Box 15945-281 • Lenexa, KS 66285-5945
(913) 492-5858 • Fax (913) 541-0156

July 23, 2009

Honorable Joseph I. Lieberman
706 Hart Senate Office Building
Washington, DC 20510

Honorable Susan M. Collins
413 Dirksen Senate Office Building
Washington, DC 20510

Re: Alexander G. Garza, MD, MPH
Nominee for Assistant Secretary for Health Affairs and Chief Medical Officer, DHS

Dear Senators Lieberman and Collins,

On behalf of the National Association of EMS Physicians (NAEMSP), I wish to convey our support for the nomination of Alexander G. Garza, MD, MPH, FACEP to be Assistant Secretary for Health Affairs and Chief Medical Officer for the Department of Homeland Security (DHS). NAEMSP is an organization of nearly 1300 physicians and other professionals partnering to provide leadership and foster excellence in out-of-hospital emergency medical services. It is our members who are often on the front lines of planning and implementing the medical response to all forms of disaster, including the sort that DHS considers and plans for on a continuous basis.

I have personally known Dr. Garza for several years, predominantly through his scholarly work and his involvement with NAEMSP. Over that time he has garnered significant experiences as an EMS physician, providing medical direction for multiple organizations at various local, regional and statewide levels. His military background also adds to his credibility as a planner and on-the-ground problem solver. He has distinguished himself, through his achievements, as a clinician, educator, and administrator.

For the past several months, until his recent nomination, Dr. Garza served as the chair of our quality improvement committee, focusing on efforts and strategies to continuously improve the overall quality of our nation's emergency medical services systems. That this is his focus within our professional organization speaks about who he is and where his efforts are spent.

I am confident you will come to know Dr. Garza as a genuine and capable physician and leader. I certainly hope, on behalf of NAEMSP, that you will find him to be the appropriate candidate for the post to which he has been nominated.

Respectfully,

Theodore R. Delbridge, MD, MPH
President



111 Eighth Avenue
New York, NY 10011
212-824-3903 Phone

July 24, 2009

The Honorable Joseph Lieberman
Chairman
Senate Committee on Homeland Security and
Governmental Affairs
SD-340
Washington, DC 20510

Dear Senator Lieberman:

WebMD/Medscape has worked with Alex Garza, MD, over many years on a very unique community health project, resulting in the donation of several hundred thousand textbooks and several million journals to Iraqi physicians and other healthcare professionals. As we collaborated on this project over the last 6 years, we have found Dr. Garza to be a rare physician—someone who is able to see larger health concerns in a global way, while also identifying and implementing the steps needed to make change happen on a very practical level. It is a unique individual who does both tasks very well—envisioning the larger need while also tackling the everyday responsibilities of making things happen.

In the summer of 2003, while Dr. Garza was serving as an Army Captain in Tikrit, Iraq, he became concerned about the lack of resources the Iraqi physicians had to do their work. Textbooks, when available at all, were very old, often many editions out of date. Updated medical journals were a rare luxury.

Around that same time, Dr. Garza came into contact with the son of a retired military physician, David Gifford, MD (whose son was also serving in Iraq). After initial email communications, Drs. Garza and Gifford decided to try to make a difference by asking US physicians, nurses, and other healthcare professionals to donate textbooks, journals, and other resources for direct distribution to Iraqi health professionals. At that point, they reached out to many sources to try to find a way to get the word out. That is when WebMD/Medscape became involved.

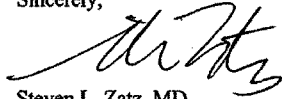
Working with Susan Yox, Editorial Director at WebMD/Medscape, a plan was developed. Dr. Garza wrote an article for publication on Medscape entitled *Help for the Healthcare System in Iraq: A Call for Donations* (Medscape Nurses, 2003. www.medscape.com/viewarticle/459771). We published that first article on our website, and the response was beyond expectations. Over time, this totally volunteer project resulted in medical professionals worldwide sending thousands of packages of journals and books for distribution in Iraq.

The initiative has continued since 2003 with efforts by subsequent volunteers and has resulted in donations of hundreds of thousands of textbooks and over a million journals.

See Donations of Texts, Journals Help Rebuild Iraq's Medical Library, Clinics (Medscape Medical News, July 29, 2004. <http://www.medscape.com/viewarticle/484446>) and *Donating Medical Books and Journals to Iraq -- The Need Continues* (Medscape Today, January 4, 2006. <http://www.medscape.com/viewarticle/518624>).

We urge your utmost consideration of Dr. Alex Garza as Assistant Secretary for the Office of Health Affairs and Chief Medical Officer for the Department of Homeland Security.

Sincerely,



Steven L. Zatz, MD
Executive Vice President, Professional Services

cc: Honorable Susan Collins
Alex Garza, MD via email: alexgarza@cox.net
Susan Yox, Editorial Director, WebMD/Medscape



Health Department

Director's Office

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July 24, 2009

The Honorable Joseph Lieberman, Chairman
Committee on Homeland Security and Governmental Affairs
340 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Chairman,

I'm writing this letter in enthusiastic support of Dr. Alex Garza's nomination for Assistant Secretary for Medical Affairs and Chief Medical Officer for the Department of Homeland Security.

I believe he is uniquely qualified because of his wide variety of experience in both the public and private sector. Not only has he been both a paramedic and board certified emergency room physician but has had substantial experience at all three levels of government, local, state and federal/military levels. As we know emergency response requires coordination at all these levels and always begins with the local response. Dr. Garza has had experience with the cross-contamination of positive anthrax samples from the Brentwood facility here in Kansas City in the Fall of 2001 and he has dealt with the Katrina evacuation of 40 plus children from their children's hospital relocated by plane to our children's hospital. All the children were transported within 45 minutes of the plane landing on the tarmac at our downtown airport. This included several children who were on ventilators. In addition he's has state level responsibility for the oversight of the EMS in New Mexico and distinguished military service.

In my opinion, the most important qualifier for this position comes from what I call the, Colin Powell Probability 40/70 Rule, "if you act before your 40 percent certain you're acting too soon, but if you wait until you're more than 70 percent certain you've probably acted too late and have missed the opportunity to save lives or take advantage of the situation." This applies directly to the EMS system here in Kansas City.

I know Dr. Garza from having had the privilege of supervising him. He came to me one day with evidence that the science was becoming very clear that we were not getting the survival rates that we needed to be getting from patients with ventricular fibrillation. He suggested that we needed to change the protocols and do more chest compressions before we tried to convert to normal rhythm. When we changed our protocols in early Spring 2006, there were only two other systems that had made these protocol modifications.

The Honorable Joseph Lieberman
July 24, 2009
Page 2

The reason I raise this is that the leader of the Department of Homeland Security must be able to way the evidence, be an advocate when change is needed, be willing to take the responsibility and risk of moving forward. Because of Dr. Garza's experience at all three levels of government, I have confidence that our nation will follow his lead and improve our ability to protect our citizens from whom intentional, manmade attacks or the even more pressing challenge of natural large scale events like H1N1.

Thank you for thoughtful consideration of his nomination.

Sincerely,



Rex Archer, MD, MPH
Director of Health

c: The Honorable Susan Collins

Senator Daniel K. Akaka
Additional Questions for the Record
Nomination Hearing of Alexander Garza
July 28, 2009

1. The National Biosurveillance Integration Center relies on in-house analysts and also on personnel detailed from participating agencies. Early this year, Memorandums of Understanding (MOU) had been signed with seven agencies, and discussions were taking place with other agencies to sign an MOU. The level of participation from each agency has varied. What will be your goal in terms of agencies' participation in the National Biosurveillance Integration Center and how will you achieve this?

If I am confirmed, building capacity is one of my key goals. Though I view this as a cross-OHA goal, I feel this should be a particular priority for the NBIC. If confirmed, my ultimate goal is that NBIC be a robust tool that informs senior leaders and state and local governments, both before and during biological incidents. To achieve this goal, it is critical that all remaining agencies actively engage with NBIC to ensure an accurate and complete biological common operating picture. I am familiar with the MOU's signed by the various agencies as well as the discussions currently taking place. My goals are to meet with my counterparts at the various agencies as well as with the Secretary, to build relationships, and demonstrate to different agencies the mutual benefits of this voluntary relationship. As a founding member of the Kansas City Fusion center, I have experience working across agencies, and I have worked extensively with law enforcement, public health officials and other public and private agencies. Moreover, I was a Civil Affairs operator, responsible for working across the various military branches such as finance, engineers, MP's and the surgeons cell to complete missions. One of the hallmarks of DHS and the OHA is the 360-degree situational awareness that must be achieved to provide the Secretary actionable and quality information. In order to achieve this NBIC must be able to acquire the right data, make correct analysis and deliver product. If confirmed, you have my commitment that this will be a priority.

2. During the early stages of the outbreak of the H1N1 virus, employees who interacted with travelers daily at the Customs and Border Protection and Transportation Security Administration received conflicting guidance. I asked the Department to clarify their guidance to employees, and I have not yet received a response. What steps will you take to ensure that the Department's employees receive clear and consistent guidance on their rights and responsibilities if the H1N1 virus has resurgence this fall as expected?

The employees of DHS are our most valuable asset and they need to have the best training, equipment and guidance in order to do their jobs effectively. Guidance is only valuable if it is clear and understandable. If confirmed, as the Secretary's advisor on health and medical issues, I will provide the Secretary, the FEMA Administrator, the Under Secretary of Management and the components including CBP and TSA, the best science-based guidance on all health threats, not just H1N1, for DHS employees. I have this kind of experience. As a battalion surgeon, I was responsible for making sure the commander had the best intelligence and information regarding mission oriented position posture, immunizations, and other health threats with the area of operations. However the OHA and the Secretary must ensure that health

security planning for our workforce takes into account scientific evidence and that the planning is synchronized with the current threat posture. I will continue to work closely with all of our interagency partners to maintain a common operating platform and provide the Secretary with clear evidence based advice so that she can execute clear guidance to our workforce.

3. *On June 16, 2009, the Subcommittee on Oversight of Government, the Federal Workforce, and the District of Columbia held a hearing entitled, "Protecting Our Employees: Pandemic Influenza Preparedness and the Federal Workforce." The hearing focused on a Government Accountability Office (GAO) report that reviewed pandemic preparedness plans for the Federal workforce. The Office of Personnel Management (OPM), Department of Homeland Security (DHS), and the Department of Health and Human Services (HHS) presented testimony on this issue. According to GAO, only one agency of 24, the Department of Housing and Urban Development, responded that it sought input from Federal employee unions when preparing its pandemic plan. Do you plan to work with Federal employees and their unions when further developing guidance for DHS on pandemic workforce plans?*

In my oral testimony I spoke of building capacity. This means ensuring that stakeholder input is a key part of OHA policy development. Employee unions undoubtedly have experience and insight to contribute to these discussions. The unions play an important role as advocates of their membership, a substantial part of the DHS workforce. If confirmed, the Office of Health Affairs (OHA) will work closely with employees and the operational components as they interact with their unions. I would ensure that we ask our components for feedback from unions to inform our development of guidance as OHA addresses protection of the workforce using sound evidence and best science available.

Senator Susan M. Collins
Additional Questions for the Record
Nomination Hearing of Dr. Alexander Garza
July 28, 2009

1. *Dr. Garza, I am interested in your ideas on ways to increase coordination between DHS and the Department of Defense when it comes to disaster medical response. You have a broad knowledge base on these issues, serving for 10 years as a public health officer with DOD and attending to our troops in Iraq as a battalion surgeon. Most recently, you were Director of Military Programs at Washington Hospital Center. In our investigation of the failed response to Hurricane Katrina, this Committee found serious gaps in the coordination and communication between DHS and DOD. What can be done to further improve this coordination, specifically in the area of disaster medical response?*

The keys to filling this serious gap are ensuring communication, interaction and planning before the event occurs. This cannot be done on an ad hoc basis or after an event. If confirmed, one of my priorities is building OHA capacities. This includes our interaction with other federal partners and in particular DOD. In order to improve our coordination in disaster medical response, the OHA should be working with DOD as well as HHS and FEMA to best define roles, responsibilities and capabilities and construct a streamlined, executable plan when the mission overwhelms all resources and requires military involvement, as in Katrina. Having served on active duty and as a member of the US Army Reserves Medical Corp, I bring key history and knowledge to OHA in their discussion of these matters with DOD. Additionally, as the director of Military Programs at the Washington Hospital Center, I interacted with the Joint Task Force Capital Region Medical Command headed by VADM Mateczun. I am confident I can leverage these relationships to foster and solidify strong partnerships and work on a solid operating platform with our other disaster response agencies to avoid any of the problems that were readily apparent in previous disasters. If confirmed as DHS Assistant Secretary and Chief Medical Officer, I will work along with DHS and partners in the interagency process to expand the relationship with DOD where necessary to improve disaster medical response with special attention to the application of the lessons learned from Hurricane Katrina.

